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AMERICAN HOSPITAL  
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*Twenty-second Annual  
Conference*

Held at Montreal, Quebec  
October 4th to 8th, 1920

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Dr. Robert J. Wilson, Director, Health Department Hospitals, New York City. Term expires Convention, 1921.

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Trustee, Union Hospital,  
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Director, Health Department Hospitals,  
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Dr. Christopher G. Parnall, Secretary, Medical Superintendent and Director, University Hospital, University of Michigan, Ann Arbor, Michigan.

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1921

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Dr. R. B. Seem, Director, Albert Merritt Billings Memorial Hospital, Chicago, Ill.  
Dr. A. K. Haywood, Superintendent, Montreal General Hospital, Montreal, Quebec.

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#### LEGISLATIVE.

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WINFORD H. SMITH, M.D.  
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tal, Baltimore, Md.

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Supt., Presbyterian Hospital,  
Chicago, Ill.

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Supt., Johns Hopkins Hospital,  
Baltimore, Md.

RICHARD P. BORDEN  
Trustee, Union Hospital, Fall  
River, Mass.

MARY L. KEITH, R.N.  
Supt., Rochester General Hospital,  
Rochester, N. Y.

## PREVIOUS CONVENTIONS—CONTINUED

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Massachusetts General Hospital, Boston, Mass.
2. A. B. TIPPING  
Touro Infirmary, New Orleans, La.
3. SISTER IRMENA, R.N.  
Missouri Catholic Hospital Association, St. Louis, Mo.

#### *Executive Secretary*

HOWELL WRIGHT  
308 Anisfield Building  
Cleveland, Ohio

#### *Treasurer*

ASA S. BACON  
Presbyterian Hospital,  
Chicago, Ill.

#### *Trustees*

A. R. WARNER, M.D., Chairman  
Supt., Lakeside Hosp., Cleveland, Ohio.

ASA BACON, Supt.

Presbyterian Hospital, Chicago, Ill.

MAJOR RICHARD P. BORDEN  
Trustee, Union Hospital, Fall River, Mass.

MISS MARY L. KEITH, R.N.  
Supt., Rochester Gen. Hosp., Rochester, N. Y.

ROBERT J. WILSON, M.D.  
Director, Health Dept. Hosps., New York City.

### XXII—MONTREAL, QUEBEC, OCTOBER 4-8, 1920

#### *President*

JOSEPH B. HOWLAND, M.D.  
Supt., Peter Bent Brigham Hosp., Boston, Mass.

#### *President-Elect*

LOUIS B. BALDWIN, M.D.  
Supt., University Hospital,  
Minneapolis, Minn.

#### *Vice-Presidents*

1. H. E. WEBSTER  
Supt., Royal Victoria Hospital, Montreal, Canada
2. R. G. BRODRICK, M.D.  
Director of Hospitals, Alameda County Hospital, San Leandro, Cal.
3. MISS MARGARET ROGERS  
Supt., Jewish Hospital, St. Louis, Mo.

#### *Executive Secretary*

A. R. WARNER, M.D.  
Office of the Association, 22 E. Ontario St., Chicago, Ill.

#### *Treasurer*

ASA S. BACON  
Supt., Presbyterian Hosp., Chicago, Ill.

#### *Trustees*

JOSEPH B. HOWLAND, M.D., Chair.  
Supt., Peter Bent Brigham Hospital, Boston, Mass.

ASA S. BACON  
Supt., Presbyterian Hospital, Chicago, Ill.

LOUIS H. BURLINGHAM, M.D.  
Supt., Barnes Hospital, St. Louis, Mo.

REV. MAURICE F. GRIFFIN  
St. Elizabeth's Hosp., Youngstown, O.

RICHARD P. BORDEN  
Trustee, Union Hospital, Fall River, Mass.

MISS MARY L. KEITH, R.N.  
Supt., Rochester Gen. Hosp., Rochester, N. Y.

ROBERT J. WILSON, M.D.  
Director Health Dept. Hosp. New York City.

MINUTES OF THE  
TWENTY-SECOND ANNUAL CONFERENCE  
of the  
AMERICAN HOSPITAL ASSOCIATION

Montreal, Quebec, October 4-8, 1920

GENERAL SESSION

OCTOBER 5, 1920—10:00 a.m.

PROGRAM

Dr. Joseph B. Howland in the chair:

*Invocation*—by Rev. George Duncan, D.D., Church of St. Andrew and St. Paul.

*Address of Welcome*—by Honorable Mederic Martin, Mayor of Montreal.

*Address of Welcome*—by the Honorable Ernest R. Decary.

*President's Address*—by Joseph B. Howland, President of the Association, Superintendent of the Peter Bent Brigham Hospital, Boston, Mass.

A motion was unanimously adopted providing for the appointment by the Chairman of a Committee of five to consider the President's Address and make report as to any points which, in their judgment, require action.

*Report of the Trustees*—Read by the Executive Secretary, Dr. A. R. Warner. Accepted and ordered placed on file.

Dr. A. R. Warner, the Executive Secretary, presented his resignation as a member of the Board of Trustees.

*Report of the Executive Secretary*—By Dr. A. R. Warner, Executive Secretary of the Association. Accepted and ordered placed on file.

*Report of the Treasurer*—By Mr. Asa Bacon, Treasurer of the Association. Accepted and ordered placed on file.

A report upon the distribution of the Red Cross gauze to hospitals was presented by the Secretary in the form of the original correspondence on this matter, with the statement that any report attempting to state clearly the situation would be too long to present and the suggestion was made that the President appoint a small committee to go over the correspondence and make report to the Association. President Howland appointed Mr. Daniel Test and Dr. John M. Peters as such a committee. Accepted and ordered placed on file.

GENERAL SESSION

OCTOBER 5, 1920—2:00 p.m.

Dr. J. B. Howland in the chair:

PROGRAM

"The Place of the Dispensary in the Public Health Program of the Future"—By Mr. John A. Lapp, Director, Social Action Division, National Catholic Welfare Council, Editor, "Modern Medicine."

"Community Hospitals as a Solution of the Rural Health Problem"—By Dr. F. E. Sampson, Superintendent Greater Community Hospital, Creston, Iowa.

## SECTION ON OUT-PATIENT WORK

OCTOBER 5, 1920—8:00 p.m.

Mr. John E. Ramson, Chairman, in the chair:

### PROGRAM

The report of the Out-Patient Committee was read by the Chairman. Accepted and ordered placed on file.

"The Relation of the Out-Patient Department to the Hospital Proper"

—By Dr. Ralph B. Seem, Director Albert Merritt Billings Memorial Hospital, Chicago, Ill.

"Traveling Clinics"—Mr. J. J. Weber, Editor, Modern Hospital.

## SECTION ON HOSPITAL ADMINISTRATION

OCTOBER 5, 1920—8:00 p.m.

Dr. R. B. Seem in the chair:

Dr. Seem excused on account of other duties.

Dr. A. C. Backmeyer, Secretary, takes the chair:

### PROGRAM

"Some Essential Factors in Efficient Hospital Administration"—By Dr. Malcolm T. MacEachern, Supt. Vancouver General Hospital, Vancouver, B. C.

Discussion—By Mr. Pliny O. Clark, Supt. Presbyterian Hospital, Denver, Colorado.

"The Selection and Organization of the Hospital Personnel"—By Dr. C. G. Parnall, Medical Superintendent and Director, University Hospital, University of Michigan.

Discussion—By Dr. Winford H. Smith, Superintendent, Johns Hopkins Hospital, Baltimore, Md.

"Keeping Up with Administrative Progress"—By Dr. Harold W. Hersey, Supt., New Haven Hospital, New Haven, Conn.

Discussion—By Dr. Louis H. Burlington, Supt., Barnes Hospital, St. Louis, Mo.

## GENERAL SESSION

OCTOBER 6, 1920—10:00 a.m.

President Howland in the chair:

The Chair appointed the following as the committee to consider the President's Address and the Report of the Executive Secretary:

Dr. M. T. MacEachern,

Mr. D. W. Springer,

Mrs. Eitel,

Dr. C. W. Munger,

Miss Daisy Kingston.

### PROGRAM

"Community Funds for Maintenance and Capital Expenditure"—By Mr. Pliny O. Clark, Superintendent, Presbyterian Hospital, Denver, Colorado.

Discussion:—"Money Obtained Through Private Benefactors"—By Dr. Frank Clare English, St. Luke's Hospital, Cleveland, Ohio.

Discussion:—"Money Obtained from Public Taxation"—By Mr. Howell Wright, Executive Secretary, Cleveland Hospital Council, Cleveland, Ohio.

"Industrial Clinics in General Hospital"—By Dr. Wade Wright, Industrial Hygiene Department, Harvard Medical School, Cambridge, Mass.

## SECTION ON NURSING

OCTOBER 6, 1920—8:00 p.m.

Miss E. M. Lawler of Baltimore, Chairman, in the chair:

### PROGRAM

"Affiliation between Schools of Nursing and Universities"—By Miss Jean I. Gunn, Superintendent of Nurses, Toronto General Hospital, Toronto, Ontario.

"The Use of Hospital Helpers in Hospitals"—By Miss Claribel A. Wheeler, Superintendent of Nurses, Mount Sinai Hospital, Cleveland, Ohio.

"The Preparation of the Student Nurse for Public Health Nursing"—By Miss Annie W. Goodrich, Director of Nurses, Henry Street Settlement, New York City.

"The Student Nurse Recruiting Movement"—By Miss Carrie Hall, Superintendent of Nurses, Peter Bent Brigham Hospital, Boston, Mass.

## SECTION ON HOSPITAL CONSTRUCTION

OCTOBER 6, 1920—8:00 p.m.

Dr. George O'Hanlon in the chair:

### PROGRAM

"Distribution of Food in Hospitals as Related to Hospital Construction"—By Mr. Frank Chapman, Superintendent, Mount Sinai Hospital, Cleveland, Ohio. Mr. Chapman's paper read by Dr. A. C. Bachmeyer.

Round Table Discussion on Hospital Construction.

## GENERAL SESSION

OCTOBER 7, 1920—10:00 a.m.

President Howland in the chair:

A motion made by Mr. Howell Wright authorizing the incoming President to appoint a special committee to study the Subsidy System—as suggested in the report by Mr. Pliny O. Clark—to make a report to the Trustees with recommendations during the coming year and also to make a report with recommendations to the next Conference was adopted.

### PROGRAM

"Function of the Social Service Department in Its Relationship to Administration of Hospitals and Dispensaries"—By Miss Ida M. Cannon, President, American Association of Hospital Social Workers; Director, Social Service Department, Massachusetts General Hospital, Boston, Mass.

"Treatment and Care of Patients in the Gray Nuns' Institutions"—By Sister Saint Gabriel, Montreal, Quebec.

Report of Social Service Survey—By Mr. Michael M. Davis, Jr., Chairman, Director Boston Dispensary, Boston, Mass. Accepted and ordered placed on file.

## SECTION ON SOCIAL SERVICE

OCTOBER 7, 1920—2:00 p.m.

Miss Imogene Poole in the chair:

### PROGRAM

"Medical Social Work as a Therapeutic Factor"—By Miss Edna G. Henry, Director of Social Service, Indiana University, Indianapolis, Ind. Paper read by Dr. Anna Richardson.



"Occupational Therapy and Placing of the Handicapped"—By Miss Lilly E. F. Barry, Honorary Secretary, Catholic Social Service Guild, Montreal, Quebec.

Discussion:—By Miss N. F. Cummings, Managing Editor, The Hospital Social Service Quarterly, New York City.

"Problems of the Social Service Survey"—By Mr. Michael M. Davis, Jr., Chairman, Committee on Study of Hospital Social Service, Boston, Mass.

Discussion:—By Dr. Anna M. Richardson, Field Secretary.

Discussion:—By Miss Ida M. Cannon, President American Association of Hospital Social Workers, Massachusetts General Hospital, Boston, Mass.

## ROUND TABLE

October 7, 1920—2 p. m.

Mr. Asa Bacon, Chairman, in the chair:

General Discussion of Hospital Problems.

The following Advisory Committee appointed to hold a session October 8, 1920, for the purpose of giving advice and assistance to such members as may appear before it:

Frank E. Chapman, Cleveland, Ohio.  
Sister M. Genevieve, Youngstown, Ohio.  
Dr. Harry J. Moss, Baltimore, Md.  
Dr. John M. Peters, Providence, R. I.  
Mr. Pliny O. Clark, Denver, Colo.  
Dr. M. T. MacEachern, Vancouver, B. C.  
Dr. A. K. Haywood, Montreal, Quebec.  
Daniel D. Test, Philadelphia, Pa.  
Dr. W. L. Babcock, Detroit, Mich.  
Dr. F. A. Washburn, Boston, Mass.

## JOINT GENERAL SESSION

OCTOBER 8, 1920—10:00 a.m.

American Hospital Association, American Conference on Hospital Service, and the American Association of Hospital Social Workers.

Dr. Joseph B. Howland, President of the American Hospital Association in the chair:

### PROGRAM

Address: The Service which the Conference Can Now Render to Hospital Personnel Through the Hospital Library and Service Bureau—By Dr. Frank Billings, President American Conference on Hospital Service.

Dr. Frank Billings, President of the American Conference on Hospital Service, takes the chair:

*A Summary of Reports* presented by Dr. John M. Dodson, Dean, Rush Medical College, Chicago, Ill.; Miss Mary C. Wheeler, Superintendent, Illinois Training School for Nurses, Chicago, Ill.; Miss Mary Antoinette Cannon, Social Service Department, University of Pennsylvania Hospital, Philadelphia, Pa. (in place of Miss Edna G. Henry).

## GENERAL SESSION

OCTOBER 8, 1921—2:00 p.m.

### PROGRAM

The President in the chair:

The report of the Auditing Committee was presented by Dr. H. J. Moss and accepted and placed on file.



The report of the Committee on Legislation was presented by Dr. A. K. Haywood and accepted and placed on file.

The report of the committee to consider the address of the President was presented by Dr. M. T. MacEachern and accepted and referred to the Trustees with power.

The report of the Time and Place Committee referring applications to the Trustees with power was read by the Chairman, accepted and approved.

The report of the Committee on Gauze was presented by Mr. D. D. Test. Accepted and placed on file.

The report of the Committee on Nominations making the following nominations was read by the Chairman:

For President-Elect—Dr. George O'Hanlon, Bellevue Hospital, New York City.

First Vice-President—Dr. M. T. MacEachern, Vancouver General Hospital, Vancouver, B. C.

Second Vice-President—Mr. S. G. Davidson, Youngstown General Hospital, Youngstown, Ohio.

Third Vice-President—Miss Alice M. Gags, J. N. Norton Memorial Infirmary, Louisville, Ky.

Trustees—Dr. Louis H. Burlingham, Barnes Hospital, St. Louis, Mo., to fill the vacancy caused by the resignation of Dr. A. R. Warner; Miss Mary M. Riddle, Newton Hospital, Newton Lower Falls, Mass.; and Mr. H. E. Webster, Royal Victoria Hospital, Montreal, Quebec; to serve for the regular term of three years.

Treasurer—Mr. Asa Bacon, Presbyterian Hospital, Chicago.

A motion was adopted instructing the Secretary to cast one ballot for the nominees as presented.

A motion was made by Dr. George O'Hanlon, expressing the thanks of the Association for the efforts made by the members of the Local Committee and the City of Montreal in behalf of the Association in the arrangements for the conference then closing. This motion was adopted by rising vote.

The Twenty-second Annual Conference of the American Hospital Association then adjourned.

## AMERICAN HOSPITAL ASSOCIATION

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, October 5, 1920, 10 A. M.

President Howland in the Chair.

THE CHAIR: The Convention will please come to order. We will open by an invocation by Rev. Dr. Duncan.

DR. DUNCAN: Oh, thou eternal source of light, we owe our lives to thee. Thou eternal source of truth, we bless thee for the growing knowledge of life's law. Thou eternal spirit of love, we thank thee for that spirit which inspires us to seek each other's good, for minds that patiently seek the truth, for hearts that beat to help and heal earth's ills, for hands of skill that bless the sick and suffering and diseased; for those that give themselves to the service of their fellows, we bless thee. With faith in life and in fairer living on earth, we would follow in the light that comes to us from thee; we would reverence the laws that seek thy will in mankind's greater good; we would share the smiles of Him who blessed others in thy name, and so prove fellow workers with thee for a better, happier, wholesomer world, which would mean that thou art most surely found in the good of all thy children. Grant thy blessing upon this Convention now assembled, that it may tend to the glory of thy name and the good of mankind, through Jesus Christ our Lord, who taught us to pray, saying, Our Father which art in Heaven, hallowed be Thy name, Thy Kingdom come; Thy will be done on earth as it is in Heaven. Give us this day our daily bread, and forgive us our trespasses as we forgive them that trespass against us, and lead us not into temptation, but deliver us from evil. For Thine is the Kingdom and the power and the glory, forever and ever. Amen.

THE CHAIR: We are greatly honored this morning in having with us the Chief Executive of the City of Montreal, a very busy man, and I know that he is called upon so frequently that his time is exceedingly valuable. It gives me great pleasure to introduce His Worship, the Mayor of Montreal.

(Mayor Martin delivered an address of welcome in French.)

THE CHAIR: The Hon. Mr. Decary, Minister of Quebec, has also consented to come to us this morning. It was not his intention to speak, but I am sure we want to hear a word from him.

MR. DECARY: Mr. Chairman and members of the American Hospital Association: It is indeed a very great pleasure, as a representative of the Quebec Bureau, to offer to you a word of very sincere welcome to the very old Province of Quebec. At a time when all through the world nations are looking not only to the reconstruction of buildings and things of a material order, but more especially when nations are looking to the physical rehabilitation of humanity, it is a source of pride for the Province of Quebec to have in its midst so many conventions of medical associations from your great country.

THE CHAIR: On behalf of the Association, I desire to thank the representatives of the City of Monreal and the Province of Quebec for their kindness in coming to us this morning.

President Howland then delivered his annual address, as follows:

We meet here today for the Twenty-second Annual Conference of the American Hospital Association. As I was unable to be present at the convention held last year in Cincinnati, when you paid me the great honor of making me your president, please let me thank you now. I want also to take this opportunity of thanking the members of the board of trustees for their ready response to calls for meetings during the year. Except for their willingness to drop their own work and make long journeys to meet for the discussion of Association affairs, little could have been accomplished. As it is, I hope you will feel that real progress has been made.

To me it has been very interesting to look over the transactions of former conferences. Beginning twenty-two years ago as an Association of Hospital Superintendents, formed, according to its constitution, "to meet together for the interchange of ideas," there has been gradual and healthy growth until now the American Hospital Association is recognized as one of the important national organizations for the advancement of hospital standards.

It was particularly interesting to me to read the report in 1908 of a Committee on Development of the Association. The principal topics mentioned in that report for future consideration were: the wisdom of having a coun-

cil, or house of delegates; a permanent secretary; division of the annual meetings into general sessions and section meetings; incorporation of the association; and collecting hospital literature in some central place. Is it not noteworthy that all but one of these things have either been adopted or are at present in process of adoption. Membership has broadened until every phase of hospital work is represented in your membership. With the extension of membership has come also a broadening of the purposes of the Association. A vote of the trustees this year whereby the Ohio Hospital Association was accepted as a geographical section of the Association seems to me to mark a most important step forward, in fact, so important as to warrant calling it the beginning of a new era in our history. There is no doubt in my mind that the acceptance of the Ohio Hospital Association marks but the beginning of a series of similar affiliations and that this coming year will see the formation of several new geographical sections. I am confident this will continue until every state in the Union and every province in Canada will be similarly represented. It seems to me that the Association can grow but little more before we shall have to accept the only one of the suggestions of the committee of 1908 not already in effect, viz., the formation of a council or house of delegates. Even now there are doubtless present many members who came to listen to the papers on hospital problems and to take part in the discussion of them and who would be glad if business matters could be discussed at a separate session by their appointed representatives.

The gift of the Rockefeller Foundation of a substantial sum of money toward the support of a reference library of hospital literature and for the collection of hospital plans and specifications is a very important occurrence. This will be under the direction of a board of trustees appointed by the American Conference on Hospital Service, of which this Association is a member. It will be the duty of every one of us to support the library by contributions of plans, specifications, and costs of our new buildings. The establishment of such a library will be of the utmost value in the future planning and equipment of our institutions. I hope the library will also include a complete file of hospital forms always kept up to date by additions and eliminations each year. The establishment of such a central reference library, now assured, has been long awaited and our thanks are due to the Rock-

efeller Foundation for making this possible. Its use cannot fail to raise materially the standards of hospital building, equipment, and organization.

At the risk of still further anticipating what the executive secretary may report for the board of trustees and in his own report, I should like to speak of one or two matters.

Last October a full time executive secretary was appointed. We were fortunate in securing for this important office one who had the previous year been your president and who was familiar with the affairs of the Association. That he has given a good account of himself you need no assurance from me. You have seen bulletins from his office, which I am sure have proved helpful, and I personally know that the business routine of his office has been placed on a very practical basis. The reference library which I have spoken of is located in the same building with your Association headquarters, and it is to be hoped that the frequent use of both will be made.

A service bureau on dispensaries and community relations has been established. A committee of the trustees has under consideration recommendations as to the formation of a bureau on hospital planning. It seems to me the establishment of still another bureau should have serious consideration. I refer to a bureau of hospital standards and supplies, somewhat similar to the New York bureau, of which some of you are members. Do we not all sometimes wonder if the supplies we purchase are the most suitable and economical for our purposes? If we had a bureau to which we could turn for advice on this subject, it would prove to be of the greatest assistance to us. Some bulletins have been issued during the past year by the executive secretary containing information of value as to standards, and of opportunities to purchase surplus government supplies; but it is too much to expect that the secretary can do much along this line without the assistance of someone devoting himself constantly to such work. It may well be that all we would ask of such a bureau could not be provided from the present income of the Association, but a small fee from a large number of members would allow the secretary to obtain the services of an expert purchasing agent and necessary clerical assistance.

In this connection let me urge all those whose hospitals are not represented by institutional membership to do their utmost to have them so represented.



This past year, which has been such a difficult one in many ways, has, I am sure, taxed us all to do our utmost to effect necessary economies. It is almost certain that some good has come to us in that we have found what we could do without. As better times come we must take great care again to review what we have done, that we may at the earliest possible moment restore such things as we have eliminated, which may have lessened our efficiency. We must try to associate at all times economy with efficiency in our hospital affairs.

Much effort is being made to improve the standards of many phases of hospital work. Your trustees have endorsed the efforts of the American College of Surgeons in their campaign in this direction.

It has seemed to me for some time that one thing which is of great importance to medical progress has been too often neglected. That is the necessity of obtaining a larger number of autopsies. It is well within the province of hospital executives to take a hand in this matter, and it is certain that if sustained efforts are made by all of us to influence the public to see the advantages to them, now and in the future, in permitting post-mortem examinations in all our fatal cases, we can do a great service to medical science. Many of our small hospitals do not, of course, have resident pathologists, but those who believe in the good to come from checking up the clinical work of their hospital with the actual anatomical findings in all fatal cases will find means of obtaining the services of a competent pathologist. The present percentage of autopsies in hospitals is a most variable one, and usually reflects exactly the amount of effort made to obtain them. At the Peter Bent Brigham Hospital it has varied from 41 to 51 per cent in past years. At present the percentage of autopsies for this year to September 1 is 56 per cent. Our lowest month was 32 per cent and our highest 75 per cent. Other hospitals can undoubtedly show still higher figures. Is it not worth our while to do all we can in this important matter?

The shortage of nurses, which most hospitals have experienced, is uppermost in our minds. Today we face in the lack of pupils and graduate nurses one of the most serious problems hospitals of this continent have had to face. It is not wholly a new subject, for twelve years ago Miss Nutting, who read a paper before this Association, on "Some Problems of the Training School," said:

"This lack of good applicants for admission to some

training schools, while a matter not only of present discomfort and distress, is of grave import. It seems ominous to those who, familiar with the training school problem as it presses daily, can see no way out of the complicated state of affairs."

Does not this sound much like what is being said today? Somehow we have gone on during the twelve years since Miss Nutting wrote as I have quoted, and we shall continue to do so. Just what we shall need to do to keep up the supply of desirable applicants, I shall not try to state here. Much thought is being given to the subject and a discussion of it forms part of our program. We know that there is not alone a shortage of nurses at the present time. The shortage applies to almost every other profession and field. No doubt in getting back to normal we shall have to make many changes in our present ideas.

Last February the Rockefeller Foundation called a conference of educators, hospital trustees, superintendents, and superintendents of nurses, from all parts of the United States and Canada, to consider the problem of the education of nurses, which is closely linked with the shortage of women entering this field, and as a result appointed a committee to consider the subject and report recommendations. We shall all await that report with the greatest interest.

The Rockefeller Foundation has also shown its interest in the subject of training hospital administrators, and at their invitation a conference on the subject was held last February. President Vincent said, in calling the meeting:

"There is a distinct and growing conviction that the demand for able hospital administrators can no longer be adequately met through the existing methods of training."

It was a most interesting conference, followed after a long discussion of the subject by the appointment, by President Vincent, of a committee to report their recommendations. As both this committee and the one appointed to consider the nursing situation are thoroughly representative of our hospitals, we may look forward with confidence to the expectation that their reports will aid us.

We have come to this convention to listen to papers on various topics of interest to us and to discuss them. Not least of all, we have come together to renew acquaintances.

May we all go away with renewed courage to keep up the responsibilities of the coming year.

**THE CHAIR:** We will hear next the report of the Board of Trustees, by the Secretary, Dr. Warner.

**DR. WARNER:** The trustees held three meetings last year. The first at the Hotel Manhattan, New York City, October sixth. All the trustees were present at this meeting. The second meeting was held at the Hotel Statler, Cleveland, Ohio, February second. Six trustees were present at this meeting. The third was held at the office of the Association in Chicago at which seven of the trustees were in attendance.

At the first meeting held in New York the future and permanent location of the home office of the Association was considered. After an extensive discussion of the advantages of every city which seemed to have any advantages, it was determined that the location of the home office of the Association should be in Chicago. The Executive Secretary was authorized to close the Washington office as soon as practical and to arrange for the transfer to Chicago. By appropriate resolution the Executive Secretary was authorized to open temporary offices in Cleveland and that the Association might secure the advantages from the help of Mr. Howell Wright in taking over the Cleveland office of the Association and closing the Washington office and that ample opportunity might be given for making satisfactory arrangements for opening the Chicago office.

At this meeting also the present Executive Secretary was elected to fill the vacancy caused by the resignation of Mr. Howell Wright.

The Service Bureau on Dispensaries and Community Relations of Hospitals was authorized with Mr. Michael M. Davis, Jr., as its chief. This action of the trustees is important as this is the first Service Bureau of the Association put into operation. Heretofore the Association has offered to its members only such service as could be arranged voluntarily or performed by the executive secretary.

A committee of three composed of the Executive Secretary as chairman, Rev. M. F. Griffin and Mr. Asa S. Bacon was appointed to work out a plan for the organization of the State Hospital Associations as geographical sections of the American Hospital Association and for the combination of personal memberships in the American Hospital Association and in the various state hospital associations.

At the meeting in Cleveland the executive secretary reported upon the question of quarters for the office in



Chicago and recommended that the Association take offices in the building to be occupied by the editorial offices of *The Modern Hospital* and *Modern Medicine*, and also the central office of the Social Action Division of the National Catholic Welfare Council. This building also contained additional space which it was planned to lease to other organizations representing hospital interests. This location is three blocks from the American Medical Association and only a block from the new home of the American College of Surgeons. After an extensive discussion of the advantages and disadvantages of the location of offices of the Association in such a group, the executive secretary was authorized to lease and equip rooms in this building. This was done and all members are urged to visit and inspect the home offices of the Association at 22 East Ontario Street, Chicago.

The committee appointed to consider the organization of the State Associations into geographical sections of the American Hospital Association and the combining of personal memberships with the corresponding memberships of state hospital associations reported at the meeting. The following action as it appears in the minutes represents the conclusions of the trustees on this subject.

"VOTED: That a State Hospital Association may be approved as a Geographical Section of the American Hospital Association, provided that for every member of such State Association eligible to active or associate personal membership in the American Hospital Association there shall be annually collected and paid to the State Association from and by such members membership fees not less than the corresponding fees required by the American Hospital Association, and that the State Association shall pay annually to the American Hospital Association for every associate member \$2.00 and for every active member \$5.00; and that, upon receipt of such payments, there shall be paid and allowed by the American Hospital Association to such State Association for every active member \$2.00 per annum to defray the expenses of the State Association as a section of the American Hospital Association. The State Association, when approved as a section of the American Hospital Association, shall furnish lists to the American Hospital Association of members for whom the amounts of \$2.00 and \$5.00 annually have been paid, and the members so listed shall, if eligible to corresponding membership in the American Hospital Association, be entitled to all the privileges of personal membership in the

American Hospital Association, in their respective classes.

"If on inquiry by the Secretary it shall appear that such arrangement shall not be satisfactory to State Associations, a report shall be made to the Board of Trustees for further consideration."

At this meeting also there was authorized the following entry in the minutes, which should receive attention from the Committee on Constitution and By-Laws:

"The Executive Secretary reported the receipt of several applications for a modified institutional membership from organizations representing various health activities, requested in order that they might have a connection with the American Hospital Association and know about its work directly, not through a personal membership in the American Hospital Association of some officer of their organization. Voting power did not seem to be desired in these applications and it was the judgment of the trustees that it would be unwise to grant voting power to large members of such organizations for the reason that it would weaken the direct responsibility and control now in the hands of the hospitals. After general discussion the trustees referred the matter to the Committee on Constitution and By-Laws with the expression of opinion that the creation of an Associate Institutional Membership was desirable that such interested organization might become such members and that these memberships should entitle their representatives to rights and privileges similar to those granted to associate personal members."

The question of sanatoriums as active institutional members was submitted for decision and it was decided that if the sanatorium "was really a reliable institution for the honest treatment of patients by medical methods in good standing," it should be admitted to active institutional membership.

The Service Bureau on Dispensaries and Community Relations was authorized to conduct in the name of the Association a survey of Hospital Social Service Work with funds provided by a donor especially interested in this work. A Committee representing all angles of Hospital Social Service Work was appointed by the president with Mr. Davis as chairman, and a field secretary employed. A report of this study will be made by the committee to the Association.

At the meeting held in Chicago, June 30, 1920, the formal application of the Ohio Hospital Association for recognition as the Ohio Section of the American Hospital Association was presented by Mr. F. E. Chapman, ex-

ecutive secretary of the Ohio Hospital Association, together with copies of the resolution passed and the new Constitution and By-Laws at the last meeting of that Association. The trustees decided that the Ohio Hospital Association had complied with all the requirements, and therefore voted unanimously as follows: "That the Ohio Hospital Association be and hereby is accepted and recognized as a geographical section and authorized to act as the geographical section of the American Hospital Association in the State of Ohio." Ohio organized the first State Hospital Association and it was therefore particularly fitting that the Ohio Hospital Association should be the first to become a state section of the American Association.

The Service Bulletin (No. 15) on the subject of the "Minimum Standard" for the professional work as worked out by the American College of Surgeons was submitted to the trustees at this meeting and approved. Five thousand of these bulletins have since been sent out to hospitals and hospital trustees.

The executive secretary was authorized to secure and employ persons qualified to perform special work for such services as is desired and requested by hospitals, at cost to institutional members and the cost plus a reasonable percentage to cover general overhead to others than institutional members.

The definite plans and policies of organization of the Hospital Library and Service Bureau, organized by the American Conference on Hospital Service, was presented at this meeting, together with information concerning the recent appropriation of the Rockefeller Foundation to this Library and the conditions under which the gift was made. As it is assured by the organization of the Library that anyone active or interested in hospitals may secure such information and data as the Library has collected or compiled without fee or charge, the active support and a contribution toward the maintenance of this Library from the American Hospital Association seemed proper. It was, therefore, voted that the sum of \$1,000 be appropriated from the funds of the Association towards the maintenance of this Library for the year ending July 1, 1921.

The Conference has leased the large library room and other privileges in the same building as our offices to house this Hospital Library and Service Bureau and a Director and two assistants are now at work collecting information of all kinds which is of value to hospitals and hospital personnel.

The application for incorporation of the American Hospital Association in the State of Illinois has been prepared and is now before the Secretary of State, but the formal papers announcing the legal recognition of the incorporation have not as yet been received.

THE CHAIR: We will now have Dr. Warner's report of the work of the Executive Secretary for the past year.

(Dr. Warner read his resignation as a member of the Board of Trustees.)

SECRETARY WARNER: At the time of my selection it was decided to let this matter rest until this Convention and that my resignation should be presented promptly to this Convention at this time.

Dr. Warner then presented his report as Executive Secretary.

The present executive secretary began work October first—just a year ago—and the year has been extremely happy and interesting to him. It has been a real pleasure to watch the Association grow in strength and usefulness and to be a part of this growth. The Report of the Trustees gives the essential points of the formal decisions and accomplished acts of the year. May this report be permitted to present to you the past, only as a background, and to deal with the future with its prospects and its possibilities.

It was at first a question as to the effect of the development of institutional membership on the personal membership. Would the superintendents of institutional members retain their personal membership and would others choose between the two? For a time the personal membership list as a whole decreased slowly, then remained stationary, then it began to increase more rapidly, then it declined. It is now steadily growing. About half of the recent increase is from trustees and the other half divided between superintendents and others. Superintendents of institutional members have never formed an appreciable part of the resignations. Two facts are made clear by these statements. First:—superintendents have as a whole decided that they wish a connection and standing in the Association independent of the hospital, and second:—that more trustees are recognizing that the American Hospital Association is a factor in the development of the hospital field and wish to be associated with it. Both these facts bring to us responsibilities and obligations which must be met fully, earnestly and promptly.

Membership—institutional as well as personal—must always be worth more than it costs. We must study the

opportunities for service to each class and make definite provisions for each. Obviously the greater service to individuals lies along the line of aiding personal acquirement of good experience, knowledge and skill in the fulfillment of personal responsibilities. This applies to trustees and department heads as well as to superintendents. Conventions with instructive programs and published proceedings, aiding hospital publications to secure and print helpful matter, encouraging a wider acquaintance, and direct personal assistance are good, but they are not enough. There is need for more.

In the past year two opportunities have been recognized and developed by the trustees which will have large value both to personal and to institutional members.

First: The establishment of the Service Bureau on Dispensaries and Community Relations with the man at the head of it who knows more about these subjects than any other in the country, Mr. Michael M. Davis. Mr. Davis is paid by the Association for the service the Bureau renders personal members and personal members should feel perfectly free to place problems before this Bureau for advice. In fact, you are paying for it. Surveys or other field work are essentially for the institutions, not for persons, and such work is done by the Bureau at cost to institutional members and at cost plus 10 per cent to cover overhead for institutions not institutional members. Other service bureaus are planned but await the finding of just the right person for the chief and for the development of greater income for the Association.

Second: The development of the Hospital Library and Service Bureau by the American Conference on Hospital Service presented another opportunity. This Library will collect as rapidly as possible all known facts and figures in regard to hospital construction, organization and operation with the desired compilations, averages, etc., and be prepared to furnish them free to anyone interested enough in hospital work to ask an intelligent question. The most of the funds for the Library are provided by the Rockefeller Foundation, but the Association is paying its full share of that proportion which must be raised by the Conference that every member may feel perfectly free to ask the service of the Library to secure desired information. We ask, however, that each will provide the Library promptly with any information it may desire from you. You will hear more of this Library later in these meetings.

The direct cost of the items of service, primarily to per-



sonal members, mentioned above without addition of any overhead or general expense has amounted in the past year to more than the total dues received from personal membership. The Association needs more personal members. There are thousands of hospital superintendents, trustees and other hospital personnel in the country who need the Association. If we all work together, we can make our service to personal members reach more and become more valuable.

Our trustee members are benefited directly by all the program mentioned above. Perhaps they will use the Library and Service Bureau more than others, but has the Association done all it could to keep them (especially those in the smaller communities, and those who cannot attend the annual conventions) informed of the progress in the development of the modern hospital? This matter must receive our careful consideration.

The growth in institutional membership during the past year has been in some ways quite satisfactory to your secretary. The time had come for the majority of the hospitals to pass judgment on their membership and to make it a reality by drawing their check for their first annual dues. The decisions were willfully and deliberately forced by bills and pointed requests to pay up. Only one superintendent wrote in a resignation for his hospital and this was withdrawn and the bill paid on being reminded of the fact that the application for membership was signed by an officer representing ownership of the institution, and therefore, a resignation must come from the same source. Four applicants have as yet never made the necessary preliminary remittances so their certificates have never been sent to them and they are not included in the list of members. At the present time a total of only \$551.00 is due the Association for institutional membership dues to the end of the calendar year 1920. These facts indicate that institutional membership is clearly and definitely established and accepted.

Your secretary is fully conscious, however, of the fact that some hospitals made the decision not so much on what institutional membership had actually done for them as upon what they realized the Association could do through the development of institutional membership. It is evident that in this there is an expression of the responsibilities of the Association and a challenge to us to make good on our job. No union or association under any name has ever prospered unless it "delivered the goods" to its members, and the American Hospital Asso-

ciation has no reason to expect any special dispensation of justice. But when we realize that the most that we ever can be expected to give—1, is the same protection and freedom for growth we all wish for ourselves and for others, but so developed as to apply to institutions and to be effective against other organized factors; 2, the totals and averages of our own routine facts and figures, but so assembled and set forth as to tell a story and be an inspiration; 3, advice and guidance from the experts among us, but so organized that the direct advice from the right man is available whenever and wherever needed; 4, and the prompt and general dissemination of any special information and new ideas that may come to any of us, but after due consideration and test—when we consider that these are all we can ever be expected to give in return for any membership, it does seem that we should be able to accomplish it. Nothing new must be created by the Association—it is all a matter of assembling, of organization.

The number of institutional members has increased slowly but steadily during the year and more of the initial correspondence is now direct with some member of the Board of Trustees. Enough has come in to enable us to live and to work. It has seemed better to defer any general campaign to increase the institutional membership until we had to our credit some actual accomplishments due to institutional membership and at least a little something to indicate that there will be direct returns. We have them now and extensive development in institutional membership should soon be accomplished.

Our service as a clearing house for hospital positions—at least for superintendents, assistant superintendents and department heads has been disappointing. A large number of the keenest and best hospital workers in the country desiring a change have registered with us just because it seemed to them the logical thing to do, but it has not occurred to many hospitals or even hospital superintendents to make any inquiry of our office when positions are vacant. If the office of the Association can be notified of vacancies, we can soon build up a real service both to the personal members and to the hospitals.

To your secretary it appears that the problem of developing fixed definitions or standards for the units used to measure hospital work and activity belongs peculiarly to the American Hospital Association. If it is our job, why not get at it? There is every reason for figuring the "days of treatment given" exactly alike in every hospital. It is simply waiting for an exact definition to be published

as "standard." There are many other facts and figures annually reported by hospitals under many similar names without uniformity in the facts or names. In talking hospital operation why do we not all learn to talk a common language instead of local dialects?

May we make the suggestion that the president appoint a special committee of superintendents to meet with all the trustees attending this convention as a committee to develop a few but definite recommendations along this line to be presented to this convention for consideration and adoption. Some figures and definitions are now *almost* standard and general. The approval of the Association of the report of such a committee would in a very short time establish definite standards for data and figures in general use. We have the opportunity to do this bit of standardization and it is expected of us, but to accomplish this the cooperation of trustees is essential. There are however enough trustees present to enable us to develop a report which will be accepted by the Hospital Boards generally.

This year has given your secretary a viewpoint of the past work of the Association which—as a member and general officer—he never knew. It has not been possible to make things go with the speed one would desire. He has been compelled to recognize the existence of that form of human inertia called "precedent." Perhaps it is well that all this is so, but from it he has acquired a new and clearer understanding of the tasks of the long series of voluntary secretaries, then of Doctor Walsh and of Mr. Wright. He has realized that the accomplishments of the past year would have been much less without their work as a foundation.

THE CHAIR: We will now have the report of the Treasurer, Mr. Bacon.

Chicago, September 22, 1920.

Board of Trustees,

The American Hospital Association,  
Chicago.

Dear Sirs: We have audited the accounts of the American Hospital Association for the period of ten months from November 1, 1919, to August 31, 1920, and submit herewith a statement of Cash Receipts and Disbursements, General Fund, for the period.

The cash balance at August 31, 1920, amounts to \$4,269.12. The balance in bank was verified by reconciliation with the balance as certified to us by the depository.

Petty cash fund of \$50 was verified by count.



In addition to these funds, your Association had on November 1, 1919, Liberty bonds amounting to \$550 which were carried as an investment of the Life Membership Fund. During the period there has been transferred from the General Fund to the Life Membership Fund the sum of \$150. This fund at August 31, 1920, amounts to \$750.44, as follows:

U. S. Liberty Bonds.....	\$550.00
Cash in Union Trust Company Savings Account..	200.44

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\$750.44

The bonds are held by the Union Trust Company for safekeeping and we have received their certificate verifying the balance in the Savings Account.

Yours faithfully,

ARTHUR YOUNG & Co.

#### EXHIBIT A

#### *Statement of Cash Receipts and Disbursements—General Fund—for the Period of Ten Months from November 1, 1919, to August 31, 1920*

Balance, November 1, 1919.....	\$ 5,575.52
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#### Receipts:

Institutional Membership Fees.	\$ 6,132.00
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#### Personal Membership Fees—

Active .....	\$4,549.00
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Associate .....	557.00
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Life .....	225.00
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5,331.00

#### Commercial Exhibits—

1919 Exhibit .....	\$ 475.00
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1920 Exhibit .....	3,165.00
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3,640.00

Interest on Bank Balances....	96.72
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Donation from Mr. E. G. Stillman for Social Service Survey	3,000.00
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Reimbursement from American Dietetic Association for proportion of 1919 Convention Expenses .....	253.33
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Reimbursement from American Conference on Hospital Service for expenditures in their behalf .....	185.50
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Miscellaneous .....	7.70
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18,646.25

Total .....	\$24,221.77
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Disbursements:

Office of the President—General	\$	60.31	
Office of the Treasurer—General		26.56	
Board of Trustees—			
General .....	\$	12.40	
Traveling .....		310.78	
			323.18
Office of the Secretary—			
Salaries .....	\$9,032.50		
Equipment .....	1,557.20		
Supplies .....	921.13		
Traveling .....	833.05		
Petty Cash .....	485.25		
General .....	2,124.46		
			14,953.59
Convention Expense—			
General .....	\$ 728.00		
Commercial Exhibits	204.07		
			932.07
Service Bureaus—			
S. B. D. & C. A., Philadelphia, Pa..	\$ 604.99		
Social Service Survey	2,112.05		
Bureau of Dispensary and Community Re- lations .....	60.00		
			2,777.04
Committees—			
Out-Patient .....	\$ 155.02		
A. C. H. S. Nursing Committee .....	74.88		
			229.90
Donation to American Confer- ence on Hospital Service Li- brary .....		500.00	
Transferred to Life Member- ship Fund .....		150.00	
			19,952.65
Balance, August 31, 1920.....	\$	4,269.12	
As follows—			
Cash in Bank, Union Trust Company, Chicago .....	\$ 4,219.12		
Petty Cash Fund on hand...	50.00		
			\$ 4,269.12

THE CHAIR: The Secretary has one word more that he wishes to say.

SECRETARY WARNER: You all heard something about the distribution of the Red Cross gauze. I have in my hands the original correspondence between the American Hospital Association and the Red Cross in this matter. All the story that there is to tell is right here. I wish to make the suggestion that the President appoint a committee to go over this correspondence, to determine to their satisfaction definitely two points. The first—I do not know how much this is needed, I hope it is not needed at all, but at least it is well to have it done—determine that the officers of the American Hospital Association did all that could reasonably be expected of them to preserve the original plan of distribution. The second point for them to determine is the falsity of the rumor, which has had some publicity, that the gauze manufacturers, the gauze finishers, were responsible for the change in the distribution program. Both those points, or at least the last, can be definitely determined from this correspondence.

THE CHAIR: I think we can all understand the feeling of the Secretary in this matter. I have personally been through this voluminous correspondence and I am certain that everything that the Secretary, then the President of the Association, could do was done. However, I appoint Mr. Daniel Test, of Philadelphia, and Dr. Peters, of Rhode Island, as a Committee to look over this correspondence, as requested by the Secretary.

DR. W. H. WALSH: Is new business in order?

THE CHAIR: Yes.

DR. W. H. WALSH: As a preliminary to the proposal of certain amendments to the Constitution and By-laws, I would like to say, first, that no reflection is intended in these proposed amendments, on any of the present officers of the Association. However, a condition has arisen which shows a defect in our Constitution, and I therefore feel, and I think you will feel the same way, that we should so amend our Constitution as to prevent the possibility of the same thing occurring at another time, when we may not have such distinguished gentlemen as our officers. The amendment proposed to the Constitution is that no member of the Board of Trustees shall hold any position for which a salary or gratuity is paid. That is a sound business principle which we should adopt at the earliest possible moment. The next proposal I have to make is one

which, looking at the Association during the last few years from afar, seems to me very necessary. There is an opinion amongst a great many that the control of the Association is getting out of the hands of the members; they do not feel as though they have very much to say about what is being done. Of course, as a former Secretary of this Association, I could say to you that you may feel quite safe in the hands of the men who are handling the business of the Association. With the distinguished Board of Trustees we have, there need be very little fear that anything will ever go wrong. At the same time, I feel as though there would be a great interest stimulated if the Association could nominate the Nominating Committee. At the present time, as you all know, the Nominating Committee is appointed by the President. The Nominating Committee, having been appointed by the President, are his appointees; he could, if he wished, instruct them. We are not proposing this because of any such incident, but at the same time we believe that there is a manner of electing the Nominating Committee from the floor which can be done very expeditiously, and I have written this out and I will now submit it to the President for the usual disposition, which will be reference to the Committee on Constitution and By-laws.

MR. DANIEL TEST: I do not think we ought to adjourn without some reference to the Board of Trustees and our Executive Secretary and the very helpful suggestions contained in the reports. I am not going to try to analyze them, because it would take too long, but I am sure that I voice the feeling of everyone when I refer to the splendid work of the Executive Secretary and the Trustees during the past year. It is not with any thought of criticising the trustees for not having pushed one idea a little harder, but to suggest that the incoming trustees should take up especially and push the question of efficiency in hospital management. I suppose that no one will contradict me when I say that there is no other business, as a whole, in America that is so poorly managed as the hospital business. With our very serious financial conditions, it seems to me that this fact is the most important thing before the hospital world today. It seems to me that the American Hospital Association should this next year make that its foremost effort.

MR. SPRINGER, of Michigan: I do not know anything about the policy of this organization, but I know that in a good many organizations they find it very advantageous,

after the reports of the officers have been given and listened to with considerable interest. to have a committee appointed to consider those reports, and then bring in, at the business meeting, suggestions as to the action that should be taken by the organization. I move that the Chair appoint a committee of five who shall consider the President's address, the report of the trustees and the report of the Executive Secretary, and make a report later as to any points which, in their judgment, require action on the part of this body as a whole.

The motion was adopted.

MR. WEBER, of Modern Hospital: Is it not in order to make a motion that both the report of the Trustees and of the Secretary be accepted and placed on file? I make such a motion.

The motion was adopted.

The Convention then took recess until 2 P. M.

## AMERICAN HOSPITAL ASSOCIATION

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, October 5, 1920, 2 P. M.

PRESIDENT HOWLAND in the chair.

THE CHAIR: The first paper this afternoon, Dr. Sampson's paper on Rural Hospitals, requires the use of a lantern. The lantern man for some reason is not here, so we will have the second paper first, The Place of the Dispensary in the Public Health Program of the Future, by Mr. John A. Lapp, Director, Social Action Division, National Catholic Welfare Council, Editor, "Modern Medicine."

MR. JOHN A. LAPP: Ladies and gentlemen: What I have to say or to read this afternoon is not new. I suppose that those of you who are progressive thinkers in the crowd will say it is old stuff. On the other hand, I think that many conservatives and reactionaries might say that it is revolutionary. They probably would call it Socialistic, and possibly, in modern terms, they might call it Bolshevistic, but my observation is that in these matters many things take place right in our midst and go a long way before reactionaries and conservatives really know that anything has happened; and in the field of public health and in the growth of dispensaries, you could describe things today exactly as they are and some folks would think you were talking about a millennium.

The subject assigned for this paper permits of two major prophecies and the coordination of the results of those prophecies. One prophecy attempts to state what the future dispensary will be; the other to outline the future public health. The coordination consists in determining what rôle the future dispensary will play in the future public health.

The paper might be written of the far distant future and describe Utopian society in which "Heaven is a little nearer earth than now" and might indulge in fanciful suggestions for a perfect state. It is not written from that standpoint. It is written for the immediate future, a future which most of us will probably see and of which we shall be a part. I prefer to speak of a time not more than ten to twenty years distant. There will be nothing fanciful, therefore, about the picture which is drawn. It will be merely a projection of what appear to be present plain tendencies into the future. It will be based upon what we know of the permanent enlargements of the present health promoting machinery of the country. It will treat the movement for better health as evolutionary, indicating the gradual completion of the process of health organization now emerging from the chaos of blind striving to advance humanity.

The term "dispensary" as used in this paper follows the definition given by Davis and Warner, to-wit: "A dispensary is an institution which organizes the professional equipment and special skill of physicians for the diagnosis, treatment, and prevention of disease among ambulatory patients." It is understood here that the term "physician" comprehends all medical and social services necessary for the purpose stated. It will be reasoned that this definition covers the organization of medical skill and equipment for the care of all classes of people, including the poor who cannot pay, the middle classes who can pay moderate fees, and the well-to-do or wealthy who can pay whatever may be necessary.

#### POSSIBILITIES OF THE FUTURE PUBLIC HEALTH

The place and actual function of the dispensary in the future public health can be better seen after we have summarized in outline the future public health. We proceed, therefore, to the projection into the future of existing tendencies in public health. What will be the future of the movement for public health? We may be certain that one of the early results will be increased interest and vastly increased resources for the promotion of public



health. Even if the increase in appropriations by public authorities increase no faster than they have during the last ten years, we shall find prodigious sums available from the public treasuries for public health. Upon the basis of past increases, I predict that by 1935 the federal, state, and local governments of the United States will be spending not less than two and one-half billion dollars annually for public health. Interest in and education for health will be accelerated at an even greater rate, and we shall find shortly that the health of the people will be universally recognized as the first concern of statesmen. These statements are not fanciful but are borne out by actual conditions and tendencies.

One of the first considerations in the enlarged programs of the future will be universal provision for child welfare. No one can mistake the tendency to provide adequately for child health and welfare. Society will see to it in the future that the child's right to be born sound, to be kept sound during the period of dependency, to be taught health principles, and to be safeguarded in early employment shall be respected. In the not distant future, maternity care will be available all over the country without regard to ability to pay. Prenatal care of the mother, visiting nurse service at birth and after, medical care at birth, and hospital care for complicated cases will be the minimum care publicly provided for the birth of babies throughout the country. Without such safeguards to the mother and the baby, outcries against race suicide lose much of their effect.

After the birth of the child, provisions will be made by society for the guidance of the mother in promoting the welfare of the child during the pre-school period. Infant feeding and child hygiene will not be left to the prejudiced ignorance of mothers; but facilities will be available for the voluntary use of parents to promote the health of their children, and those facilities will be involuntarily used eventually by those parents who willfully or ignorantly neglect the health of their children.

When the child enters school, the opportunity is afforded for adequate observation and care. The future public health will provide completely for the physical examination and oversight of all children in all schools, including physical examinations, feeding when necessary, corrections of defects, prevention of disease, dental care, preventoriums for the anemic, and mental tests and oversight. When conditions are found which endanger

the life or the physical well-being of a child which parents fail or refuse to correct, means will be found to see that the correction is made. With the physical oversight of the child lasting until the sixteenth or eighteenth year, there should be but a small percentage of defective youth growing into adult life.

The future public health will take care of the child health problem in all schools, public, private, or parochial. The present absurdities existing in some of the American states and cities whereby medical supervision is limited to the students of the public schools will be eliminated. The state has the same concern for the child's health, whether he is in one school or another.

The medical supervision of children in school will in the future not stop at the moment the youth leaves school. He will be followed into industry to see that the good work of the school is not spoiled by harmful conditions of employment. The present plans in force in some states and cities for physical examination and guidance of children entering employment and their supervision in employment up to the age of eighteen will finally become universal.

The future will show a continued and rapid growth of social medicine. Many diseases will become a matter of social care in the same way that the care of tuberculosis, insanity, epilepsy, feeble-mindedness, and some contagious diseases has already become largely socialized. The treatment of cancer is rapidly being assumed as a social problem. It does not take a prophet to see the rapidity with which social medicine will continue to narrow the field of private medical practice. Take the figures for tuberculosis alone. In 1905, when the National Tuberculosis Association was organized, hardly \$100,000 was spent by the public for the care of the tuberculous. Today the amount reaches the enormous total of \$4,000,000. Tomorrow we shall see that sum vastly increased, and soon the treatment of tuberculosis will become entirely socialized. How far this tendency will go one cannot tell; but that it will continue in increased proportions cannot be doubted.

Allowing prophecy to take wing for the moment, I would predict that one by one of the diseases of mankind which are most serious in their effects will be cared for by socialized medicine. So far as the care of disease is not socialized, there will be a marked tendency for its care by cooperative means. The people are just learning



in America to organize cooperatively for the purchase and sale of goods. Tabooed for many years by capitalist propaganda, condemned as socialistic and a failure, cooperation has nevertheless taken firm hold throughout the United States and Canada, and the next quarter of a century will doubtless be known as the era of cooperation. When people understand the principle of buying groceries by the cooperative method they soon come to understand the advantage of cooperative purchase of health. Some of this cooperative purchase of health will be obtained through the Government. The greater part of it will be obtained through mutual organizations.

We see the beginnings of cooperative health on a large scale in industry. Industrial medicine has in an incredibly short time been established as a permanent part of industry. Largely in the past supported by employers, gradually becoming a mutual concern of employers and employees, and in the future becoming a mutual enterprise of employees with contributions from the employer, industrial medicine has come to stay. We see everywhere the rapid advance of the idea of cooperative purchase of medical and health service. Plant after plant has instituted mutual benefit associations providing health insurance and as a part of health insurance providing for the purchase of medical, nursing, and hospital care. Mutual benefit associations which formerly confined themselves to cash benefits are extending the benefits to include the purchase of medical care for their members and their families. Enlargements will continue because of the recognition of the fact that medical care is even more essential than cash benefits in times of sickness. State health insurance will eventually compel all employees to belong to a mutual benefit society or to be insured in public mutuals. When that time comes, the present tendency toward that end on a mutual basis will develop into the universal system. The future will see more of a tendency on the part of groups of people going cooperatively to the hospitals, dispensaries, and the physicians and buying medical care for the group.

Lastly, the future will see an extension of the activities for rehabilitation of the cripples from accident or disease. Men will be put back on their feet at public expense, if necessary, so that they may again go it alone in life. The rehabilitation of wounded and sick soldiers in Canada and the United States has given us the background of experience to carry on this work, and in the near

future it may be said that no person will need to go without the necessary medical care for restoration, or the necessary therapeutic appliances for physical rehabilitation. Particularly will this apply to the sick poor who are under the care of charitable institutions and agencies. Thousands of such sick poor could, by adequate organization of medical and social service, be restored to working capacity and be made independent members of society.

Ten states of the Union have provided the beginnings for the vocational retraining of cripples. Congress has recently passed an act providing for national aid for vocational rehabilitation. Some of the states have been wise enough to see the whole problem and have not only provided for vocational retraining but for the physical rehabilitation of cripples as well. Pennsylvania is one of the states which now make it possible for cripples to be properly treated and supplied with the necessary therapeutic appliances to put them in a position to work or to be retrained for work. That policy will without question be made universal. The junk heap of humanity will not be permitted to remain. People will not be cast upon the junk heap and those who are there will not be compelled by the force of adverse circumstances to remain there.

What will be the rôle of the dispensary in this future program for public health? We may be certain that it will play a large part. I am inclined to think that it will play the largest part in putting the program into effect. The dispensary will be the future health guidance bureau. Its service will be utilized by all classes of people, from the very poor to the very rich. Facilities which even the rich cannot buy will be made available for all, in the same manner that facilities which the poor cannot buy will be made available to them. A striking example of this tendency is shown in the recent purchase by the state of New York, at an expense of \$250,000, of two grams of radium for the State Institute for the Study of Malignant Diseases, to be used in the free treatment of cancer.

The future dispensary will make far fewer distinctions on the score of ability to pay. It will be more of a public institution providing service for all, regardless of their financial status—not that the idea of payment for service will be eliminated, but that the burdens will be equalized and ability to pay will be judged, not by ability to pay

something, but the ability to pay the required expenses for the particular person or family involved.

The future dispensary will provide adequately for the care and rehabilitation of the sick poor, meaning by this term those who are actually under the care of charitable agencies or institutions, public or private; not those who apply for medical charity but those who are actually dependent upon material relief and are referred to the dispensary by the agency or institution caring for them or to which they apply for relief.

The charity dispensary will serve the relief agencies as medical counsel in the rehabilitation of the physically unfit and the detection of malingerers and frauds. All of the charity dispensaries of progressive communities will be coordinated to that end. When a relief society takes charge of a case, the service of the dispensary will be called upon to make a complete diagnosis of the physical and mental condition of the persons under care. This will not be a simple examination by a general practitioner, or by a young doctor seeking experience; but will be a group study of specialists coordinated in the dispensaries for work of this kind. The plan for the care of cases by social agencies will be worked out in cooperation with the dispensary and will be more and more based upon the findings of the dispensary medical group. Adequate medical care will put many persons and families on their feet and make them permanently self-supporting.

When the dispensary has made its findings, it will turn the case back to the agency from which it came, and will use the agency, in cooperation with the workers of the social service department of the dispensary, to follow the case as long as may be necessary.

There have been developed in recent years numerous types of dispensaries designed to meet the needs of particular groups. School clinics and dispensaries are well known in all parts of the country. Such dispensaries will greatly increase in numbers and in range of activities. Colleges are rapidly establishing clinics and dispensaries for the health guidance and care of students. Industries are establishing first aid dispensaries and diagnostic dispensaries and are making provision for medical care. These will rapidly increase. The time is not far distant when every important industry will maintain dispensaries not only for those who are injured and who are entitled to care under the Workmen's Compensation Acts, but also those who are sick from any cause and are thus

unable to deliver a full day's work. Public health departments and public agencies will develop more and more baby clinics, welfare stations, health centers, and clinics for special diseases. One who sees these tendencies as they manifest themselves in every section of the country must be convinced that the public, or group, dispensary is bound to play a large part in the future.

The dispensary of the future will provide adequately for those who are not in poverty but who find the medical expense for their particular troubles greater than their budgets can reasonably stand. This class, which includes practically all of the wage earners and smaller salaried people, will in the main have their risks of disability distributed by means of insurance, and the cost will be equalized for each, whether we have a five dollar or a five hundred dollar disability.

The dispensary of the future will be the servant of the well-to-do and the rich through group arrangement by physicians for group diagnosis. The growth of specialization has made group practices inevitable. The call of science demands group practice. People of all classes, wearied by the search for health among uncoordinated specialists, recognize that the specialties should be fused into a unit for the all-'round practice of medicine. Physicians are responding to this call and we see springing up in many places group clinics where adequate physical examination and diagnosis may be made for a flat fee. In some places the idea has been successfully extended to the entire practice of medicine, the physicians of the community being combined into one single corporate group for the complete practice of diagnostic and curative medicine.

The ideal dispensary has been described as "the front door of the hospital." If that means that all patients enter and leave through the dispensary, then I believe that that description will apply to the future dispensary in the future program of public health. The dispensary will be the social service agency of the hospital to keep people out of the hospital when they ought not to go there and to keep people in the hospital when they ought to be there. It will be the means of making the service of the hospital universal. At the same time it will itself be coordinated with other dispensaries and its service coordinated with all social and health agencies in public health centers.

THE CHAIR: It is certainly a glowing picture that Mr.

Lapp has drawn of the care of the health of our future generations. I am sure we all hope the day may speedily come when the things he mentions may be functioning. I will ask Dr. Parnall to open the discussion.

DR. C. G. PARNALL: There are those who would characterize Mr. Lapp and those who advocate the measures that he advocates as dreamers; but it seems to me that in this day, this era when we are getting away from selfish individualism, that what we need is vision such as Mr. Lapp has shown here. The dispensary of the past is becoming the health center of the future. The dispensary offers the missing link between curative medicine as we have known it in the hospital, and preventive medicine as exemplified in various fields of public health endeavor. Curative medicine and preventive medicine cannot logically be separated; they must go hand in hand. The dispensary of the future, as outlined by Mr. Lapp, offers the opportunity to connect the hospital and the activities of the hospital with the very lives of the people. To any one who studies the history of hospitals and of the public health movement, it must be apparent that there has been a tremendous waste of time and effort and money. We hear a great deal, of late, of the shortage of nurses. One of the chief reasons, to my mind, for the shortage of nurses is the fact that most of the people have reaped their part of the reward of prosperity, and each one feels, with the slightest ailment, that he is entitled to the services of a nurse, and being willing and able to pay for such services, he takes the nurse out of the field of service to the community or to the larger group. Now the same is true in medicine; the general practitioner of the past and of the present has been the servant of the individual; his effort consequently has been wasted; there has been an unnecessary duplication in medicine, as there has been in nursing, and it seems to me that through the establishment of dispensaries which become, in fact, community health centers, that this tremendous wastage of human effort will, to a certain extent, be stopped. With the establishment of dispensaries and health centers, as Mr. Lapp has suggested, medical men will associate themselves in groups, the better to discharge their obligations to the community, both as members of the social organization and in their professional capacities. However, it seems that we are in an era where we are emerging from individualism, where we recognize the value of cooperative effort, and where we can just as well take advantage of our ability to purchase health col-



lectively as we can, for instance, and have, purchased education for the masses. (Applause.)

THE CHAIR: Mr. John E. Ramson, Superintendent of the Michael Reese Dispensary in Chicago, is a man of large experience in dispensary work, and I am sure he has been looking into the future. We would like to hear what he has to say.

MR. JOHN E. RAMSON: Mr. Chairman: In discussing Mr. Lapp's paper, I am going to borrow a bit from the report of the Committee on Out-Patient Work, which is a part of one of the section programs this evening. Mr. Lapp's prophecies are already being clothed with the garb of reality. The various public health movements, such as the anti-tuberculosis, the campaign against venereal disease, the movement for mental hygiene, the conservation of maternal and infant life—all of these have found that the establishment and development of dispensaries and clinics is an essential part of their program. They have found, if they did not know before they started, that it is useless to teach health to a sick man unless, at the same time, you can direct him to facilities for the treatment of his disease. Thus in the program of the organizations concerned with the prevention of mortality at childbirth, they have established clinics for the examination and the instruction of expectant mothers in the hygiene of pregnancy. This has been followed up by further instruction in the home by the visiting nurse. It has been further followed by the establishment of adequate obstetrical facilities, either in the hospital or in the patient's home; and then again by the work of the nurse and by the work of the clinic in infant feeding and the hygiene of childhood. Now that program, carrying with it as an essential part, the institutional facilities, the dispensary, the clinic, has, in this particular field, reduced the death rate from childbirth and conditions incident thereto, from a position next to the top of the list, down to the very admirable percentage of less than one-tenth of one per cent, and the death rate of infants, while not reduced to such an extent as this, has been, by these same means, greatly reduced. The medical examination of school children has been taken as a great step in advance in public health, but revealing, the discovery, of defects and diseases of childhood without the establishment of facilities for their treatment and correction is of very little value. However, the establishment of clinics is coming as a part of this same program for the health of the school child. Especially is this true of

dental clinics. I was much interested the other day in finding a clipping from a North Carolina newspaper from which I want to read you a paragraph or two. The headline is "The Adenoids and Tonsil Clinic a Great Success," and it goes on to tell of a clinic operated by the State Board of Health coming down to a town with an outfit of doctors and nurses and apparatus and setting up a clinic in the high school, putting in some beds and removing the adenoids and tonsils from 57 children in three days, keeping the children in this little improvised hospital during that time. That work followed the examination of 2,700 school children in that community, of whom 355 were found to need operations for tonsils and adenoids. This, it seems to me, is an excellent example of the way in which the facilities of the hospital, especially the out-patient facilities of the hospitals, may be actually taken to the people who have no ready access to such facilities. One might say that if Mahomet cannot take his children to the hospital, the hospital can take its service out to Mahomet's children. The mental hygiene movement has found that by the establishment of clinics for the diagnosis of mental disease and for the after care of patients discharged from the state hospitals, they can, instead of having the hospital the beginning and end of the service rendered to the mentally ill patient, make the work of the hospital a part of the program in mental hygiene, and it is interesting to note that today there are more than 125 out-patient clinics of state hospitals for the insane in operation in various states of the Union. It seems to me that one may sum this all up by saying that hospitals everywhere are finding or may find their best service in the field of public health, in the development of adequate out-patient facilities.

THE CHAIR: Mr. Lapp's paper is open for discussion. We should like to hear from others.

DR. WOODS, of Indianapolis: In his introductory remarks, Mr. Lapp said that perhaps there were those who would not regard the matter of this paper as new. If there are such, surely they would not say the things he discussed are happening, because I believe it is true that hospitals generally do not regard themselves as important public health agencies. The closing remarks of the last speaker indicate that he regards the hospital as an important public health agency in its out-patient work. Now the truth is that Mr. Lapp's paper very clearly stated certain things concerning the dispensary, but implied, I

think, much broader things concerning the place of the hospital in the field of public health, and I think, Mr. Chairman, that it is true that the public health worker as well as the hospital workers, have not coordinated their fields quite as closely as they might have done. At this moment I do not recall having heard in the meetings of the Public Health Association of America, any discussions upon the place of the hospital as an institution in the field of public health, and it is important for us who are devoting ourselves to hospital work exclusively now to appreciate that we do have a very important rôle in the general field of public health today. The second thing I wish to say is that it is most gratifying to have a man who is not a hospital worker, who is not engaged in the field of public health, and, I believe, who is not primarily a medical man, come before us and present a thrilling prophecy of this sort concerning the dispensary of the future, and its relation to the public health of the future. It is true that we need to be stimulated and stirred up, frequently, by persons who are capable and who grasp our problem, from the outside, and I think many of us owe much to our friends who are not engaged primarily in our particular field, for the suggestions which they have made and the things which they have done to stimulate us, to study ourselves more closely and see whether or not we too have the vision of that day which those who are perhaps not so closely associated with us have.

DR. ANDERSON, of Raleigh, N. C.: North Carolina has a most progressive man in charge of the work referred to by Mr. Ransom. He is a man of initiative; he has thought out plans that are new, and he has put them into execution as quickly as he could get legislation to enable him to aid the school children of North Carolina. His wisdom, his enthusiasm, has enabled him to infect others. Even our Governor went before the last legislature and got the best appropriation for this special work of any that North Carolina has ever had, and Dr. George M. Cooper, in charge of this work, has not only done what was referred to, but he has held these clinics in all parts of the State and has demonstrated how practicable his plan is and how much good it can do. Under the enthusiastic leadership of the Secretary of our State Board of Health, Dr. W. S. Rankin, whom perhaps many of you know, we are getting all the money that we are able to use with our present force in the State Board of Health, and Dr. Rankin told me a few days ago that he needed



men and women to do the work that he could really do, more than he needed the money. From our Governor down we are getting our people enthused over this public health question along the lines stated, and I predict that this man with a vision has not put his vision too far ahead; we will realize it in North Carolina.

DR. SMITH, of Johns Hopkins: I do not wish to prolong the discussion, but there is one point which Mr. Lapp made in his paper which I do think is worthy of a little more emphasis, particularly his reference to the program for the rehabilitation of the physically handicapped. As I have listened to the paper and the discussions this afternoon, the thought came to me, what a change in the subject matter of our program in the last ten or fifteen years. The most of our time was spent in listening to papers on the management of the laundry, the purchase of various kinds of supplies, the per capita cost, and I can even recall that one hospital superintendent, as long ago as ten years, advocated that the meetings of the American Hospital Association each year should be discontinued, that we had about exhausted the subjects for discussion. And as I looked over the program, the realization came to me that we had changed very completely our whole trend of thought as to the subjects appropriate for discussion before this Association, a change which seems to me to have indicated a gradual realization of the greater rôle which the American Hospital has to play and must play in the whole public health program of the future; but with reference to the particular thing concerning which I wish to speak, the rehabilitation of the physically handicapped which was mentioned briefly, that is one subject concerning which we have heard very little. There were many of us who hoped that with the presentation of the problem in a larger mass as the result of the war, steps would be taken that would go far to indicate the way to be followed in the future, for the problem was not a new problem as the result of the war, but an old problem which, strange to say, we have done very little up to this time to solve. We, all of us, if we stop to think, must realize that every day we are discharging from our hospitals patients with advice given by ourselves and other members of the staff that we know, if we stop to think about it, it is practically impossible for them to follow. We discharge them with no machinery except the existing social agencies and our own social service departments to see that they are properly fitted back into their home lives, the lives of industry. It

seems to me, in brief, that one of the important things that must be handled in the near future, in order to make it possible for the public health problem and the hospital program to be carried through to a logical conclusion is to provide in every community—and I wish to stress this point, that it seems to me a community problem and not the problem of each individual hospital or dispensary, because it is the same problem for all, that there must be provided in every community the machinery which will take those individuals discharged from our hospitals with the advice that we can tell them to follow and see that they are enabled to get on their feet, whether it be that branch of the machinery which shall have to do with reemployment or proper placement in employment or with that branch of the machinery which has to do with re-education. Certain it is that because of the lack of that machinery, individuals are going through our institutions every year having done for them all that we can do for them, and then being relegated to lives of uselessness and dependency, merely because we have not gone one step further and established in our communities that sort of machinery to which they may be referred with prescriptions from the various members of the staff of any and all of our hospitals pointing out the dangers to be avoided in that particular individual case and the methods which might be employed to make that man a useful citizen in the future instead of a useless derelict. I leave it with you as one of the important things which we have to solve in the future.

THE CHAIR: Is there anything else to be said on this paper? Mr. Lapp, do you care to say something in closing?

MR. JOHN A. LAPP: I was afraid the secret would come out, so I was careful to preface my paper with a statement that it was just a projection of the things that now exist into the future. Everything I talked about is working somewhere in this country very successfully.

THE CHAIR: Those of you who come from large centers do not realize how serious is the health problem in the rural community. There are some communities of very considerable area without physicians, and it has caused great concern to know how the rural health shall be safeguarded, and many men and women have put much thought on this subject, and we have today one who has, I think, done more to work this problem out than almost anyone in the country. I refer to the one on our program,

Dr. F. E. Sampson, Superintendent of the Greater Community Hospital, Creston, Iowa.

DR. F. E. SAMPSON: The opinions here presented are based upon the experiences incident to twenty-six years of endeavor to develop efficient hospital service at Creston, Iowa, a city of eight thousand, the center of an almost exclusively agricultural area containing approximately one hundred thousand population. Of this population 60 per cent reside on farms; the remaining 40 per cent, outside of Creston, are in the county seat and other towns and villages of an area approximating four thousand square miles in extent.

The rural health problem is the aggregate of rural problems. Its relation to the urban health problem is such that the solution of either involves the solution of the other. Of course we ordinarily think of it as a problem of applied medical science. In its practical essentials, too, the rural health problem is the problem of rural hospitalization. As here used, the term "rural hospitalization" is by no means limited to institutionalizing rural pill prescribing and scalpel play.

The solvent properties which the above title by inference ascribes to the community hospital are potential in the hospital's fitness to function as a coordinator of the civic, economic, social, spiritual, and scientific forces of the community rather than in any mysterious excellence it might possess as a plant for salvaging human wreckage. It is in the activities incident to developing its hospital that the community makes progress in solving its health problem. The difficulties of such solution are those inherent in low density of population together with highly developed discrimination concerning matters of doctrine and other minor subjects for dissension.

Our rural communities, towns, and smaller cities are crippled by the multiplicity of welfare organizations. Competition is a misnomer. It is usually *contention* between agencies in the struggle for existence and these are all be-churched, be-lodged, be-clubbed, until community morale is suffocated in the scramble of organizations, straining to put over their respective budgets for denominational or fraternal hospitals in some distant city or foreign land, while locally, they are doing nothing.

In the greater community area with upwards of 100,000 population we have two churches for every hospital bed including the "goitre" type below mentioned.

The limited number (and individualistic habits) of

doctors practicing within the horizon of practicability for service as staff members, is further complicated often by manifestation of the same pathological process that leads to the hypertrophy of ductless glands. In response to the demand for products, it multiplies units that conform to the morphological type; but fail to function. I know one county that has a goitre of this kind, a county-seat town of less than 3,000 having four private hospitals (and two of its five churches are farmed to support hospitals located elsewhere).

Another complication occasionally met arises from the failure of people to realize that there is such a thing as premature acquisition of complete material equipment. Material equipment and medical service in conserving community health, are inseparably related, each reacting on the other. An imposing structure with impressive equipment, unsupported by medical and nursing talent and training, with efficient organization and administration of such, may prove little less than a calamity.

No doubt this very interesting problem of rural health depends very largely upon the presence of people in the rural community. A brief study of changes in the distribution of population would show that in certain typical agricultural communities the loss since 1900 in seven counties has been equal to one entire county.

What is the cause of this morbidity in the distribution of population, this tendency of states and nations to develop visceral overgrowth at the cost of muscularity? I wonder if it is not because city people living nearer the social equator travel faster in the spin around the whirligig axis of every day activities, because where increased density of population raises the social voltage and drives into urban consciousness the mutuality of liability there is the feeling that the lives of others must be protected to preserve the safety of oneself. With their highly developed organization, cities capitalize rural inefficiency. Denominational and fraternal executive bodies located in urban centers utilize the rural terminals of their respective organizations as collecting mechanisms.

The Greater Community Hospital at Creston, Iowa, has been developed in an environment which, in addition to the above outlined disadvantages, was dominated by a barleycorn administration which controlled the affairs of the urban center of that group of rural counties. The story of The Greater Community Hospital would be a record of reactions that occur when socially constructive

ideals fall into a pool of putrid politics and survive the plunge. It was born October 1, 1894, in a rented cottage, equipped with five beds and several hospital implements. It was organized on nonsectarian lines and incorporated under statutory provisions for benevolent institutions. Since the second year, it has been maintained without subsidies and has grown to a fifty bed institution housed in its own fireproof structures, clear of indebtedness, and could hardly now be replaced for \$200,000.

Omitting details, whys and wherefores, it is sufficient for present purposes to state that while this environment was anything but favorable for developing the type of institution here considered, it did present an ideal field for thrashing out the various factors entering into the rural health problem. Anything that could survive, say nothing of making a notable growth, in such a field, should be comparatively easy of development in the average rural region.

Out of these years of daily contact with the problem of rural hospitalization evolved the conviction that *community health is largely a community product and one which involves cooperation of local forces in local service.* Health being a fundamental interest, the most valuable measures of conservation being preventive measures and a popular education indispensable to their application, the cooperative participation of community forces in behalf of community health is the key to our rural health problem.

In line with this proposition at a convention of representative people from the several counties of the group, the Greater Community Association was organized on August 14, 1918. By a deed of gift the property and directing authority of the hospital and training school were transferred to the board of regents of The Greater Association. Of the fifteen members now comprising the board of regents, only three reside in Creston and, including these three, only six reside in Union County.

Through the cooperation of the county medical societies with the public health nurses, there was developed the basis for a series of combined children's and tuberculosis clinics held in the several counties. In preparation for these clinics, put on as county medical society undertakings, the Iowa Tuberculosis Association sent a special nurse to assist the local county public health nurse. A special children's nurse from the Greater Community Health Center, provided by Central Division Headquar-



ters of the American Red Cross, the pediatrician from the children's department of the Greater Community Hospital, a clinician from the Iowa Tuberculosis Association, and other tuberculosis specialists cooperated with local practitioners in conducting these clinics. From the abundant material located at those clinics, is now selected that for the clinics to be held at the Greater Community Hospital by members of the medical faculty from the state university. At these clinics, the county medical societies and public health nurses of the entire area assemble. To the special clinic for mentally defective or retarded children, the county and city superintendents of schools are also invited.

*The outstanding needs of the rural situation are for doctors, nurses, and social workers trained for service in these less densely populated regions, especially for hospital superintendents big enough to manage small hospitals efficiently. The refinements in scientific teaching and training of medical students in team work that involve the use of modern hospital equipment and highly developed organization may be carried so far as actually to disable men for service in the rural communities as they are today.*

While it is for the medical profession to take the initiative, it must have sustained and intelligent cooperation of *medical teaching centers and of the great organizations concerned with welfare promotion*. County medical society team work, in cooperation with public health nursing in the agricultural counties, will demonstrate the necessity for hospital facilities, and the average rural community will do its part in providing material and equipment. In recognition of this need, the Greater Community Plan contemplates expansion of hospital service, developing county units, which may be coordinated through the Greater Community Central Hospital, and under the direction of competent executives located at the center. The training of nurses in these several rural hospitals and the service of internes assigned for a certain period of their term of interne service after having worked in the city hospitals would be, I believe, not only possible, but a practical and valuable achievement.

The above mentioned gift of the hospital and training school to the Greater Community Association provides through common ownership a center of common interest. The cooperation of our state lecturer on tuberculosis, the Iowa Tuberculosis Association, the extension division and

medical faculty of our state university, with the encouragement of The National Organization for Public Health Nursing, and the American Red Cross has effected much. Through the latter it was possible to organize efficient public health nursing throughout the entire area by providing supervision at the Greater Community Center. In this way a good start has been made in the development of intercounty cooperation, thus providing opportunity to demonstrate further the mutuality of advantage obtainable from larger cooperation.

In the above described experiment, for such it is as yet, the aim is to overcome what some able and interested workers on the problem have considered insurmountable obstacles to providing adequately for this obviously vital need—the need for efficient, adequate, and readily available life and health conserving equipment in the communities where the world's basic industry thrives or deteriorates with the ebb and flow of quality as well as quantity of rural population.

The survival of the Greater Community Hospital and its growth has demonstrated the right to existence of hospitals that are organized and administered with a view to production of a balanced service in which the best obtainable equipment and the best available talent are coordinately directed to most effectively meeting the needs of the situation. In other words, conducted on the above lines, even a meagerly equipped hospital with decidedly substandard organization at the beginning is better than no hospital. Even a subdistrict rural school is better than no school at all. Standardization and legislation, indispensable as they are to the achievement of efficient hospital service, must not be prematurely featured nor overworked in handling our rural problem. Its solution is not to be achieved easily nor quickly, nor by any one organization or institution.

Besides such elements of strength as the above may have, must be considered its point of weakness. While its survival of the vicissitudes of institutional pioneering demonstrates thus far its fitness, it does not by any means assure its perpetuation. The very features that give it distinction and that have contributed largely to selling the idea extensively in fact constitute its most serious weakness. Not because they are not right, but because they are very largely the expression of a few earnest individuals, who voluntarily assuming the functions of the community, have achieved certain objectives and delivered

to the Greater Community Association, a valuable property and a going concern in the name of the community in which it was developed, in spite of indifference and not infrequently obstructive activities of parasitic political and commercially inspired professional interests.

In other words, the Greater Community Hospital in its standards, its policies of administration, its purposes, and plans for extension is not yet sufficiently understood by the local community to assure it against a disabling slump when the individual interest and efforts that have so long carried it are withdrawn, as they must be, and in anticipation of which the surviving members of the group have already initiated the weaning process.

That it is fundamentally right, I believe is beyond a doubt. The present need is to preserve its integrity and carry it across the "no man's land" which intervenes between the advance agents of social evolution and the supporting column of social understanding in the community immediately responsible for the conservation of the institution.

#### NET RESULTS TO COMMUNITY HOSPITAL

With the completion of county units contemplated in the Greater Community plan a rural training field, an aggregate hospital bed capacity of five hundred to six hundred beds be centered in the Greater Community Hospital. Besides preparing doctors and hospital superintendents for rural work and inspiring them with the spirit, acquainting them with the need and the opportunity, it will bring to these county medical societies and to the country doctors the inspiration from teaching centers and enlighten these centers to the needs of the periphery. In short, it will restore the capillary circulation to the nation's musculature and save to these fields of basic production the talent, training, and character they must have in order to save the world from the wolf and its litter of bolshevistic whelps.

DR. HORNSBY: I did not know that Iowa was as far behind as Dr. Sampson indicates. I thought they were doing some pretty fine things out there. They have got the best law that I know of on any statute book in regard to hospitals, the Iowa County Hospital Law. They built two of those hospitals years ago and they have been working wonderfully well. In the first place, the proposition to build up from nothing to something good is archaic. You cannot run that sort of a hospital; you cannot build that sort of a hospital; you cannot make that kind of a



hospital today; that is not scientific medicine, and you have no right to ask the people of Iowa or the people of any other state to follow you and support a hospital built on the program laid down for this first unit. You have got to give them something, and that something is the scientific practice of medicine, the practice of medicine according to modern methods, and you cannot do it in that kind of a shop. This last hospital ought to have been built first, it ought to have been built long ago, and they ought to have had in it the things that the people have a right to have in looking for health, the scientific things. Niney-nine out of every one hundred hospital superintendents in this country knows how to do better than she is doing. The reason that they do not do it is because they have not got the money and the reason that they have not got the money is because of the failure on our part or on somebody's part, to educate the public.

THE CHAIR: The paper is now open for general discussion.

DR. SEYMOUR, of Saskatchewan: Mr. President, ladies and gentlemen: I think that Dr. Sampson is particularly well named; the results that he has shown prove that. Dr. Hornsby said that Iowa had the best hospital law that he knew of. Now I just rather fancy that Dr. Hornsby said that not knowing that we have in Saskatchewan a hospital law that I want to tell you something about. Saskatchewan is the youngest province in Canada, but at the present time it is third in point of population. It is distinctly a rural country, an agricultural country. In that province we already have a number of large cities where very high class medical and surgical work is being done, but that does not solve the hospital problem for the people who are living in a territory of 350,000 square miles with a population of less than a million, and it is necessary to work out some sort of practical problem that would supply hospital care for these people and we have succeeded in having legislation carried into effect which is doing that. It provides a means by which money can be raised immediately and the hospital purchased, built and equipped and made into a running concern without any unnecessary delay. Dr. Sampson's plan, while he is obtaining splendid results, would not be applicable to our new province.

Our hospital act, as it is called, provides for a union of two or more rural municipalities uniting with one or more urban municipalities and forming a hospital district. When that is done, provision is made for building a hos-

pital that would meet the requirements of the community. The plans must be submitted to the Commissioner of Public Health and the question of expenditure must be submitted to the local Government Board. After these preliminaries are arranged for, provision is made for a vote being taken in the whole district, and if the vote ratifies the proposition, the people of the district must raise the money to provide the hospital and maintain it. This plan we have had in operation for a number of years and it has worked out very satisfactorily indeed. We quickly realized in that new country that a hospital was just as necessary as any other public institutions, just as necessary as a fire-hall, and the hospital for the insane and other institutions that are maintained by public taxation, and we quickly came to the conclusion that so far as the rural districts were concerned, that was the proper way to provide the hospital facilities, that every person must contribute. In that country where land has been cheap, a large number of men who are non-residents own land there. By this hospital plan of ours, they all have to contribute towards the building and maintenance of the hospital.

We have in the province at the present time, 39 hospitals in actual operation, nine of which are union municipal hospitals; we have 60 union municipal hospital districts organized but not yet voted upon; we have 24 union hospital districts in process of organization; we actually have at the present time one hospital bed in the province for every 400 of the population of the province. I made this remark in Washington last May, and the Assistant Commission of Health of the great State of New York paid a compliment to Saskatchewan to this extent, that in the far western part of Canada, in Saskatchewan, we already had an ideal greater than they were actually striving for, we already had one hospital bed for every 400, while in New York they are only trying to get one bed for every 500. This plan of ours, by which everybody living in the district contributes toward the cost and maintenance of the hospital, has been giving universal satisfaction. So far as actual cost is concerned, the cost of the site, building and equipment amount to about three-quarters of a mill on the assessment of the district; in other words, about \$1.90 per quarter section of land. When we get down to those figures, the farmer knows exactly what it will cost; it will cost him to build, equip, purchase the site and build a hospital according to an improved plan, \$1.90 per quarter section. To maintain the hospital, we

have no charity work in Saskatchewan, we believe in making people pay for what they get, and the maintenance of the hospital so far as the rural districts are concerned, is provided for in this way; everyone in the district contributes a share of the cost of the maintenance of the patients; for instance, if Tom Smith's hired man is taken to the hospital, he is taken there and if it costs ten days at \$3.00 a day, the account is sent to the Secretary of the Municipality, who sends a check for \$30.00 to the hospital and it is charged up in the tax rate. In order that John Smith may provide for himself, his family and dependents, hospital care of this kind, it will cost him approximately one and a third mills on the assessment. That is what the hospital maintenance costs; in other words, about \$3.00 per quarter section, so that for \$10.00 for a half section, which is the usual sized farm, a resident can have a hospital and equipped, maintained and provide hospital care for himself and dependents for \$10.00 a year of outlay. That survey is a most satisfactory investment far as cost is concerned.

THE CHAIR: Is there any further discussion of Dr. Sampson's paper?

MR. BACON: I would like to ask the speaker who pays the bill of the doctor and the special nurse if one is needed?

DR. SEYMOUR: The patient receiving the treatment pays the bill.

THE CHAIR: Dr. Sampson, do you wish to say something further?

DR. SAMPSON: I have to say something for my good friend's benefit that did not understand. It illustrates how far it is from the country to town. That institution I speak of started very modestly with a sub-standard equipment and did the best it could. It has demonstrated that a hospital can grow and develop without selling bonds, without subsidies, if it will deliver the goods. And it must do that. In order to deliver the goods, it did teamwork, the best it could do, and balanced it. It did not pay a whole lot for a lot of trimmings and nickel plate when it needed something in the kitchen worse; it did not put in a drug store when it needed a laboratory; it did not tolerate the hiring of a house pathologist when it could send the tissue to the University on the one hand and put something into training and dietetics on the other. He has drawn a beautiful picture but has seen it from town.

The session then adjourned.

## AMERICAN HOSPITAL ASSOCIATION

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, October 5, 1920, 8 P. M.

### SECTION ON OUT-PATIENT WORK

Mr. John E. Ransom in the Chair

**THE CHAIR:** The meeting will please come to order. The first paper on the program is the report of the Committee on Out-Patient work.

#### Significant Facts in Recent Dispensary Development

Hardly any other phase of institutional medicine on the one hand, or of public health on the other, has experienced such development in recent years as has the dispensary or clinic. Some aspects of this development worthy of particular comment are:

(a) The establishment of out-patient departments in hospitals not heretofore having such service.

(b) The rehabilitation of existing out-patient departments.

(c) The creation of many new special clinics in general dispensaries.

(d) The development of dispensaries and clinics as an essential part of such public health movements as the anti-tuberculosis campaign, the social hygiene movement, the mental hygiene movement, and the campaign for the conservation of maternal and infant life and health.

(e) The development of clinics as a part of the machinery of state boards of health as effective agents for disease prevention and health promotion.

(f) The development of health centers.

(g) Industrial dispensaries.

(h) Evening clinics and pay clinics.

(i) Consultation and group diagnostic clinics.

(j) The development of medical social service.

In general, these developments have resulted from the recognition of three facts. First, that if medical service is to be adequate in relation to community need it must be organized. Second, that the most fruitful efforts directed toward the prevention of certain infectious diseases lies in the treatment of infected individuals. And third, that the dispensary or clinic can be made an efficient and

economical organization of medical resources for the combating of disease. As these ideas gain impetus, there is dawning a new day in out-patient work. Time was, and in many instances still is, when the dispensary was housed in a cellar; equipped, if at all, with cast-off and worn-out articles from the hospital, and manned by a staff which, to say the most charitable thing about it, did not recognize dispensary service as efficient medical service. Too frequently the dispensary has warranted the description, "a poor place for doing poor medical work for poor people." Tomorrow the dispensary bids fair to become the front door of the hospital. More and more of the hospital's diagnostic work will be done in its out-patient department.

Hospitals, in increasing numbers, are coming to recognize that an out-patient department is an essential part of their organization. It is so apparent as to need only mention here that without dispensary facilities a hospital must use comparatively expensive ward facilities for treating patients who are not essentially bed patients, and must keep in the hospital other patients who might be discharged to the out-patient department if there were one.

The development of hospital social service has had no small part in bringing hospitals to this point of view. It is the social worker who more than any other member of the hospital family becomes acquainted with medical needs of persons who are not yet hospital patients, and of the hospital patient after his discharge.

Each year we see old hospitals adding out-patient departments to their activities, and in many a new hospital careful attention is given to the organization, housing, and equipment of this important part of the institution's work.

### Special Clinics

The major divisions of medicine and surgery long ago found their counterparts in dispensary clinics. With the development of specialization these major departments are being supplemented by special clinics of much more limited scope and in which much more intensive diagnostic and therapeutic work can be done. Among these special clinics the ones most frequently found are those for the treatment of syphilis, tuberculosis, heart disease, gastrointestinal diseases, diseases of metabolism, and infant feeding problems. The establishment of these special

clinics is helping dispensaries solve some of their most serious problems. To secure adequate treatment for patients and to make dispensary work attractive to good physicians are the two most difficult tasks confronting any dispensary. We are all too familiar with the kaleidoscopic picture of the busy physician rushing to his crowded clinic, "running off" in a hurried hour of two a score or more of patients with ailments ranging in seriousness from carcinoma to constipation. Under such conditions he can give or gain but little. Because of the opportunity for the study of disease problems which these special clinics afford, physicians of ability are finding a new interest in dispensary work. Because of the better medical service and because in most dispensaries these clinics have the services of special social workers, nurses, and dietitians, as the nature of the work may indicate, greatly improved service for patrons is obtainable. Present indications point to the development of increasing numbers of these special clinics and through them to increased efficiency in out-patient work.

### Place in Public Health Movements

The greatest development of out-patient service in recent years has been in relation to several public health movements. Anti-tuberculosis campaign, social hygiene, mental hygiene, infant welfare—all phrases of comparatively recent coinage—represent organized effort directed toward the solution of some of our most common and most socially significant disease problems. Some of these movements have developed various methods of attacking the several phases of their special problems. All have found the dispensary an essential and effective weapon.

As already stated, with some diseases the rendering of infectious individuals non-infectious is the most productive preventive measure. However, the clinic has other significant values than serving as a treatment station. It becomes a meeting place of those who need and those who can give instruction, advice, and inspiration, in relation to health problems.

The anti-tuberculosis movement was first in the field as a nation-wide movement for disease prevention. Its development has in a large measure been determined by its ability to secure the establishment of sanatoriums and dispensaries as centers of diagnosis, treatment and education. The directory of the National Tuberculosis Asso-



ciation published in 1920 lists 493 tuberculosis dispensaries and clinics.

The campaign for venereal disease control is another public health movement making wide use of the dispensary. Recognition of adequate treatment facilities as the biggest factor in prevention led the United States Public Health Service to make the establishment and encouragement of clinics and dispensaries an essential part of its program. A recent bulletin of the Public Health Service gives a list of 526 such institutions in which free treatment for venereal disease may be obtained.

### Clinic in State Hospitals for the Insane

Inquiry as to the out-patient activities of public hospitals for the insane brings to light a very interesting situation. One might make a list of these hospitals arranged in the ascending order of their comprehension of their function as a part of a program for the promotion of mental health. At the bottom of the list could be placed a few hospitals which make and contemplate making no provision at all for out-patient service, social service, parole, after-care, or any other extra-institutional activities. Others are just beginning to extend their interest to paroled patients, keeping in touch with them through correspondence with their families or by occasional visits of parole agents. Others have social service departments which work with patients both before and after discharge, helping them to make the difficult adjustments which face a person who has been mentally ill. Still others have established out-patient clinics both at the hospital and in communities served by the hospital. These clinics are centers for diagnosis and treatment of mentally ill persons who may be treated outside of institutions, and for the after-care of patients who have been discharged or paroled from the hospital. The list of out-patient clinics for nervous and mental diseases in the United States, published last year by the National Committee for Mental Hygiene, contains the names of 126 clinics maintained by public hospitals for the insane, and institutions for the feeble-minded and epileptic. Six are listed as conducted by mental hygiene associations.

Another public health problem which is being brought more and more frequently to public attention is that of safeguarding maternity. So inadequate and archaic are our obstetrical facilities that childbirth and conditions incident thereto stand second only to tuberculosis as a cause

to death among women of childbearing age. The development of prenatal clinics, and of clean obstetrics in hospitals and in patient's homes, have in certain communities reduced this death rate to less than one-tenth of one per cent. This movement is growing especially in the large cities. Upwards of a hundred prenatal or maternity clinics have been listed this year by the committee on out-patient work of the American Hospital Association.

The interest in child welfare is likewise finding expression in the establishment of clinics for the instruction of mothers in the feeding and care of infants, and the care and treatment of children of pre-school age. School clinics, especially dental clinics, are following the development of medical inspection of school children.

The development of clinics as a part of the program of public health movements is having a healthful effect upon established general dispensaries. These newer, special clinics, with efficient service their watchword, and the prevention and cure of disease their end, are establishing standards by which the methods and the end results of dispensary work generally may be measured.

### Clinical Service of State Boards of Health

A number of state boards of health are developing clinics in various communities as a part of their function as an agent for the protection of health. The needs of communities which have no ready access to adequate medical facilities in relation to important disease problems are also being met by state health departments by actually taking clinics to these communities. Space will permit but brief mention of these important public health activities. In some states the maintenance of tuberculosis clinics is a state function. The Pennsylvania State Department of Health maintains over a hundred of these dispensaries. Massachusetts and Illinois conduct clinics in many cities and towns for the after-care of poliomyelitis. The Bureaus of Child Hygiene of Massachusetts, Texas, New Jersey, and other states hold child welfare clinics in various places in their respective states. The North Carolina state board has done pioneer work in the South in taking to many of its smaller communities dental clinics, and special operative clinics for children suffering from diseased tonsils and adenoids. Medical inspection of school children in that state revealed such a need for correctional treatment that the state board added the

development of treatment facilities to its health promotion activities.

The New York State Department of Health, in co-operation with the State Department of Education, the State Hospital Commission, the State Commission for Mental Defectives, State Charities Aid Association and the American Red Cross, and later the American Society for the Control of Cancer, has inaugurated a series of group consultation clinics in several counties of that state, for the purpose of bringing aid not locally available to the medical practitioners in rural counties. In this way they place at their disposal adequate medical consultation service, supplemented with a diagnostic laboratory, and an x-ray department, and the encouragement of periodic physical examinations, for the purpose of an early recognition of disease conditions.

The entrance of the state into the field of providing diagnostic and treatment facilities may indicate the beginning of a movement of great significance both medically and socially.

Brief mention only can be made of the other aspects of recent dispensary development. The health center idea has found an able exponent in the American Red Cross. This organization, in entering the field of rural hygiene, is tackling one of our most difficult public health problems, the crux of which is the lack of adequate medical facilities. With the development of industrial medicine there is a constantly increasing number of dispensaries maintained as an essential part of the human maintenance departments of many industrial and mercantile establishments.

### Evening Clinics and Pay Clinics

Each year is finding a greater number of out-patient departments open one or more nights per week, to meet the needs of employed people who would otherwise have no convenient access to medical facilities. These evening clinics are not all conducted as pay clinics. A considerable number of tuberculosis dispensaries now have evening hours, for those patients who, though able to work at least some of the time, still need to be under clinical observation and instruction. The National Tuberculosis Association lists 120 out of a total of 493 tuberculosis clinics as having evening hours. The larger number of night clinics are for patients who are able to pay modest fees. These pay clinics are helping solve the health problem of that

large class of people in every populous community who are not so poor as to need medical charity, nor so rich as to be able to purchase adequate medical service, particularly the service of the specialist. Reports were received last year by the American Hospital Association of eighty hospitals and dispensaries which maintain evening clinics.

Medical social service is finding a major part of its field related to out-patient work. The social worker perhaps more than any other person is relating the work of the medical agency to the needs of the community. She is helping many a dispensary to make its work more valuable by helping to make secure and effective for the patient the results of medical treatment.

Significant of the increased interest in out-patient work are such undertakings as the development in the American Hospital Association of a service bureau on dispensaries and the community relations of hospitals. Various studies of dispensaries have been made during the last year or two. Noteworthy among these are the study of New York dispensaries made by the Public Health Committee of the New York Academy of Medicine, a considerable part of the report of which has been published in *The Modern Hospital*, the investigation of dispensaries in Illinois made by the Illinois State Health Insurance Commission, and the study of Cleveland dispensaries and hospitals which formed a part of the Cleveland Hospital and Health Survey. Of great promise is the dispensary development program of the United Hospital Fund of New York, which program was briefly outlined in a recent issue of *The Modern Hospital*.

Thus are dispensaries and hospital out-patient departments being devoted to promote public health, and to make more efficient, through organization, medical facilities for the treatment of ambulatory patients. Yet with all that has been done to improve out-patient work, the chief assets of many a dispensary are its unrealized opportunities for service. But of this we can be sure: that forces are at work to make the dispensary a good place in which good medical service is available for increasing numbers of patients.

THE CHAIR: The next paper on our program is "The Relation of the Out-Patient Department to the Hospital Proper," by Dr. Ralph B. Seem, Director, Albert Merritt Billings Memorial Hospital, Chicago, Ill.

DR. SEEM: In a consideration of the relation between

the dispensary and the hospital, the many possibilities of such a relationship which may be mutually advantageous immediately present themselves. This is particularly true when the dispensary is the out-patient department of the hospital and is housed in a building on the hospital grounds. Experience has shown that dispensary clinics have certain weaknesses when standing alone, when they do not have hospital support and hospital facilities. With the proper association between them it is possible for each institution to do better and more complete work.

Many patients require treatment as ambulatory and as bed cases, the one period supplementing the other. As for example patients suffering with chronic diseases of the heart, kidneys, lungs, disorders of metabolism, arthritis and many other conditions that are subject to acute exacerbations, need hospital care from time to time. There are a large number of patients for whom the dispensary examination indicates hospital treatment. This is particularly true of patients examined in the surgical, gynecological, nose and throat, obstetrical departments, and many others. Hospital beds are essential for the service of an obstetrical dispensary which cares for patients in their homes, patients for whom one must be prepared to meet the development of complications and conditions which can only be properly treated in a hospital. In a pediatric dispensary many patients are treated who should be admitted to the hospital in order to tide them over critical periods in the course of their treatment.

Patients discharged from the hospital, who require further observation of their response to hospital treatment, continued supervision and treatment, or dressings in a surgical case, can best be cared for in the dispensary, further observation of their response to hospital treatment, rather than having them go to the operating rooms or to the hospitals. They may return at times when it will be possible for the house doctor to see them, should that be desirable. This arrangement permits of a more intelligent after care and a better supervision of convalescence for certain types of cases. As patients pass from one department to the other it is important that the continuity of their treatment should not be interrupted.

A maternity ward with the necessity of pre-natal work and post-partum visits is handicapped without the facilities of an out-patient clinic. In a certain maternity clinic, which is a department of a large hospital, it is customary before discharge for the mothers who live within



a certain district surrounding the hospital to take their babies to the pediatric dispensary. Here the child is registered and a personal relationship is established with the mother. She is told to return with her baby at intervals for observation, or at any time, if the baby does not do well or should she desire advice concerning the health of the child. In time this institution will have available for study, valuable records of children from birth to adolescence.

Many patients apply to the hospital for admission who do not need hospital care and should be treated as ambulatory cases in the dispensary. To determine into which class patients fall often requires careful study and pains-taking examinations by one or more specialists. These can be better carried out in the dispensary than by the examining physician of a large hospital who may not have the time or the training and experience to go into the case as thoroughly as may be necessary in order to arrive at a proper decision. In hospitals where the admitting system provides for the examination of these patients by members of the house staff, there is necessarily interference with their routine hospital duties, some of which may be impossible to interrupt, with the result that the patients are often kept waiting for examination, what must seem to them an unreasonably long time. As most hospitals have more requests for admission than they have beds available it is important that they should not be occupied by patients who might be going to a dispensary for treatment or for study and observation. If the admitting officer of the hospital will exercise care in sending to the dispensary for examination, and possible treatment, all patients for whom it will not be a hardship to wait until the next dispensary hour, fewer patients will be unnecessarily admitted to the hospital wards and the time of the house staff will be conserved; also the duration of stay in the hospital will be reduced for a certain number of patients, because many of the tests and special examinations indicated for a given case can be made in the dispensary. This method has been in use for a number of years at the Johns Hopkins Hospital. During the year 1919, 3,473 patients were admitted to the hospital on recommendation of the dispensary.

Ward patients may be sent to the dispensary for examination by specialists and even for special treatment. In this way it is often possible to secure the opinion of the specialist in a shorter time than when it is necessary



to wait for him to come to the ward. The examination can be conducted more conveniently in the dispensary department, which is especially equipped for it, and the necessity of preparing for the examination in the ward will be saved. The coordinate use of the dispensary departments by the hospital staff will have a tendency to maintain on a high level the standards of work of the dispensary which should have the same medical standards and ideals as the hospital.

### Duplication of Service and Equipment Avoided

When the dispensary and hospital are located in the same physical plant, the duplication of special apparatus, equipment, and service can be saved as there are certain facilities which may be used in common. While it is desirable that there should be laboratories in the dispensary departments for the simple routine examinations, the more pains-taking tests and finer analyses should be made in the hospital laboratories. The services of technicians, and the reagents and supplies for the dispensary and hospital laboratories may be furnished from a common source. If properly located, one drug department will suffice for both. The same will be true of the mechanotherapeutic and hydrotherapeutic departments and röntgenology.

The training school of the hospital should supply the nurses for the dispensary. If the head nurse of the dispensary is a member of the staff of the superintendent of nurses, the training of the nurses while in the dispensary may be carried on without interruption. With a definite plan of supervised instruction while working in the different clinics, the pupil nurses should have a better appreciation of the health and social problems of the community because of their dispensary experience.

One social service department should serve both hospital and dispensary. That part of the work of this department which has to deal with patients who require hospital care is greatly facilitated when it is possible to follow these cases through the hospital without the necessity of transferring these patients to other agencies.

### Dispensary Staff Has Other than Monetary Remunerations

It will be found advantageous to have members of the resident hospital staff regularly assigned for work in the dispensary, for which they will be held responsible. They will not only be of assistance in carrying on the work

but as much as anything else will help to cement the tie between the work of the wards and the dispensary.

It is well recognized that it is impractical, because of the expense, to offer adequate monetary remuneration to the dispensary staff for their services, for which other means of compensation must be sought. As a hospital department, a dispensary offers greater opportunities in professional recognition and advancement. There is an added prestige in the appointment on its staff; and the associations are generally of greater value. Opportunities afforded members of the staff to make themselves expert in the diagnosis and treatment of certain types of diseases in which they are interested, may lead to their being called in consultation for cases of this kind admitted to the hospital, if not to treat them. Some institutions provide for the promotion of members of the dispensary staff, for meritorious work, to the hospital staff.

Interest in the work is also greatly increased with the opportunity of following patients into the wards, of observing their response to hospital treatment, of seeing the dispensary diagnosis confirmed or refuted, it may be by operation or at the autopsy table. The value and interest of the dispensary service is further enhanced for the dispensary staff, if it is possible to send into an observation ward for a limited period, a dispensary patient on whom it is desirable to secure continuous observation for twenty-four hours or to watch the response of the patient to a certain test or a given treatment, or to recover from the effects of a minor surgical operation. If this arrangement is possible without the necessity of having these patients admitted as cases of the hospital staff and thereby passing out of the jurisdiction of the dispensary staff, it is an especially valuable one.

A proper system of records is essential. The dispensary history should be sent to the ward and at least a resumé of the hospital findings, diagnosis, treatment, and results should be prepared by the resident staff to be recorded in the dispensary history. The records of the hospital and dispensary should be under the supervision of the same history clerk.

The question of organization is a very important consideration. The dispensary should be under the same administrative control and its medical policies should be determined by the medical board of the hospital. The chiefs of the various hospital services should be in charge

of the corresponding departments in the dispensary, where they may be represented by their associates and assistants as physicians and surgeons in charge of the departments. That the desires and opinions of those actually doing the work, I refer to the dispensary staff, may receive proper consideration, they should select from among their members, representatives who would constitute an advisory committee, through which recommendations concerning the welfare of the dispensary should be presented to the medical board of the hospital.

To secure the advantages and benefits from the correlation of the work of the hospital and dispensary suggested in this paper, some of the results will depend upon the arrangement of the building in which the dispensary is located and its relation to the rest of the hospital, more, however, upon the organization, and most of all upon the desire of each person concerned to do his or her part toward that which is considered best for the patient, and a readiness to give as well as to take, in other words an *esprit de corps*.

THE CHAIR: This subject, the "Relation of the Dispensary to the Hospital Proper," is an important one; it is something that has troubled more than one administrator of a hospital or dispensary and various workers in these institutions. The paper of Dr. Seem is open for discussion.

MR. DANIEL TEST: Our experience for just five weeks may be of interest. Recently we entirely eliminated the division between the house and the dispensary staff. We used to have a house staff and a minor staff; now the dispensary clinics are all under the chief physician, and the men who used to be dispensary chiefs are now assistants. We only put that in force five weeks ago, at the beginning of September, and the improvement in our dispensary service has been phenomenal for five weeks.

MRS. BACKUS: I would like to ask a question; how do you get your physicians on service in your hospital ward to distinguish between patients who should be sent to the dispensary and those who should not?

THE CHAIR: Will someone answer that question?

DR. SEEM: It is in the discretion of the surgeon in charge of the case, and that is his responsibility. Is the question as to whether the patient is to come back to the dispensary for subsequent treatment or go to the office of the attending physician?

MRS. BACKUS: I have had patients come to the dispensary and say "I did not want to come here, because I have

my own doctor, but I was told to come on such a date, and I came." I want to know whether there is any way of avoiding that in the hospitals?

DR. SEEM: I think the doctor who is a surgeon and is responsible for the treatment of the case of course is anxious to carry it through and see the final result. On the other hand, if it is a case sent in by some outside doctor or conference of the attending physician, it is only natural that as long as the case no longer requires institutional care, the subsequent treatment should be carried on by the family physician unless there is some particular reason why they should still return to the doctors who had charge of the case in the hospital.

MR. RICHARD BORDEN: I think the last inquirer has raised a very important question in regard to dispensary practice on both sides of the hospital proper, both on the entry and exit of the patient. The dispensary is a very important function, but there is always the question of medical attendant in the dispensary, and the medical disturbance and practitioner disturbance outside the dispensary. While always more or less idealistic propositions in regard to dispensary service can be carried on with a certain antagonism on the part of the medical profession, it has always been a problem. There is another problem; I have heard of doctors who get appointments through hospitals to the out-patient service and wait for years and years in the out-patient service, not getting what they consider a promotion to service on the in-patient side. The doctors on the contrary who have already got that promotion regard it as more or less of an undignified procedure for them to really do any of the work in the dispensary. If we could put the dispensary on a business proposition of employing a man to go in and do his work and paying him so much for it without any of these professional questions that come into the dispensary problem, it would be quite a simple matter. The discussion this morning was about the group advantages of the dispensary. That is fine; but if a public health nurse finds a patient who needs adequate treatment, who has more or less a complication of disorders, and they tell that patient to go to the dispensary where they can get group treatment, immediately there is antagonism on the part of the general practitioner, because the Public Health nurses have taken away their practice. It seems to me when we advocate all this broadening of the scope of the dispensary, it might be just as well to consider the practical problem

of policy which the hospital trustees must consider before they take any very active step in advance of the development of the dispensary practice.

DR. THOMPSON: In our particular work, in developing better facilities for the treatment of venereal disease, we have found that as dispensary facilities increased, the work of the general practitioner increased and the work of the specialist increased. We had to meet, in our national campaign, the criticism of the medical man that we were going to take the bread and butter away from his children. I think the intensive campaign that has been conducted in the last three years in venereal disease work has at least offered a suggestion towards the solution of the problem. As the public knew more about the necessity for diagnosis and treatment and long continued care, it has, to a degree at least, divided itself into its proper classification of those who need absolutely free treatment, those who need part pay treatment, paid dispensary treatment, and private care, and it has kept the work within reasonable bounds, and kept down the criticism.

MR. MICHAEL DAVIS: I would like to say just a word on the matter just touched on by Mr. Borden in relation to the medical profession and dispensary. Everyone recognizes that it is a particular subject and a difficult one of the administrator, trustee and others. I feel that one of the difficulties we face is the fact that hospitals and dispensaries generally made their plans in their own councils. Any undertaking of a hospital nature is really a co-operative undertaking and it involves the co-operative element with the administrators, trustees and others who are working in the hospital, and it is only wise and fair that there be a frank discussion, and, if possible, an understanding with the local organizer in the profession. I was very much struck recently in a city in the west, in going over the history of a controversy about this subject, it turned upon the question of pay clinics. Certain hospitals started pay clinics; there was opposition from part, at least, apparently a considerable part, of the organized medical profession. Attacks upon the clinics were made in the Medical Society, and it reached a fairly acute stage of antagonism. The Medical Society appointed a committee to investigate the subject. The committee investigated and reported, but the report was never published. It leaked out afterward that a rather remarkable thing had happened; the committee had investigated the pay clinics, a committee of the Medical Society and they had



reported in favor of the pay clinics. It seems to me that one of the ways of avoiding the difficulty is to deal frankly and openly with the organized medical profession.

DR. DELARGE: I am a Frenchman and will try to express myself as best possible, so you will understand me.

I do appreciate that the physician in charge of any dispensary, through his ability, through the appreciation from his patients, can claim much more than a salary because his private clientele is going to give him remuneration that cannot be appreciated by any hospital. This question is a very delicate one. If you do put the dispensary on a mercantile basis, you will be exposed to intrigue, to politics, to such an extent that you will not know at all where you are landing. I shall advocate no salary for the physician. His science should be given a remuneration becoming his office, if really he is giving science to it.

THE CHAIR: Dr. Seem, do you want to close the discussion?

DR. SEEM: I would like to add that I think there is a tendency today for dispensaries which are out-patient departments of a large hospital to become the diagnostic clinic for that hospital, and as that plan has developed physicians with the proper dispensary facilities, positions on the dispensary staff will be considered just as valuable and just as desirable as those on the hospital staff, and furthermore the hospital and surgical treatment will merely be a medical adjunct to the dispensary.

THE CHAIR: One of the very serious problems that confront many communities lies in the fact that many people are so far removed geographically from organized medical facilities. Even in our large cities frequently the hospitals and dispensaries are grouped in sections of the city and outlying sections far from the center of population. The rural community has suffered from the lack of proper medical organization and especially institutional facilities for the treatment of disease, so that we find today among the children of the country a larger index of disease and defect than we do among the children of the city, although we were most of us brought up to believe that the country was the healthiest place in the world in which to live. That problem is beginning to be met in a way through the establishment of the traveling clinic. The next paper on our program is traveling clinics, by Mr. J. J. Weber, editor of "The Modern Hospital."

MR. WEBER: Evidence, much of it striking in character,



is accumulating daily which goes to show that the campaign now being waged for conserving human health will not be altogether a front porch campaign. Hospitals, dispensaries, health centers and doctors' offices there will be, to which the sick, and the well who have the will to keep well, can go, with more or less convenience, for the diagnosis of their ills, treatment, periodical medical examinations, and instruction in the intelligent guidance of their footsteps along the highway of health. But health campaigners, particularly during the past five years, have not been content solely to provide buildings, equipment and medical and surgical skill to which the sick can resort for diagnosis and treatment. Rather, they have chosen to follow the advice of the parable of old and "Go out into the highways and hedges and compel them to come in." In a word, they are determined to carry the gospel of good health, and in some measure the means of attaining it, to the people themselves, especially to the people in our rural communities, where the ways of health are not always clearly understood and where modern facilities in equipment and skilled personnel for the diagnosis and treatment of disease are not always readily available. This campaign has been made possible by an interesting, and often picturesque, combination of modern educational materials and methods and modern transportation facilities. In this aggressive campaign, railway trains and parts of trains have been used, as, for example, the Sanitation and Health Train which the State Board of Health of Florida conducted during 1916 and 1917 for the purpose of delivering lectures on health and sanitation with motion pictures and slides; motor trucks, as, for example, the Cleveland Children's Year Special conducted by the Children's Year Committee of the Council of Defense of Cleveland, Ohio, in 1918, which carried exhibits, gave motion picture shows, distributed literature and conducted a dispensary for child hygiene and welfare work; motorcycles, as, for example, the Flying Squadron of Health which by exhibits, stereopticon slides and lectures carried propaganda throughout Wisconsin from 1911 to 1915 for tuberculosis prevention and cure, for the Wisconsin Anti-Tuberculosis Association; trolley cars, as, for example, the Children's Year Special conducted in 1918 by the Women's Committee of the Michigan Division of the Council of National Defense for exhibit, examination, lecture and demonstration purposes; horse drawn vehicles, such as the Health Exhibit

Wagon conducted by the Vermont State Board of Health during 1913 and used for moving pictures and health exhibits; and, to deviate slightly from our field, even the house-boat, as, for example, the house-boat "Josephine," which was chartered by the California State Board of Health to carry an exhibit of animal parasites and a working field laboratory. Doubtless we shall soon witness the White Winged Squadron swooping down from the great spaces above to deliver its message of health to human beings diseased either in body or mind. To speak at any length regarding all of these mobilized means of conveying health is clearly out of the question in a paper of this character. I shall merely attempt to touch upon a few of the salient points in the evolution of the motor truck as a traveling health clinic, and record some of the latest developments and results.

Any organization contemplating the use of this instrument for accomplishing some of its work, particularly for publicity purposes, will find not only the health publicity campaign, but also campaigns relating to a variety of other vital subjects, rather fully discussed in Mrs. Mary Swain Routzahn's book on Traveling Publicity Campaigns, published last year as one of the Survey and Exhibit series of the Russell Sage Foundation, New York City.

Traveling clinics usually have any one of three main purposes:

*First:* General or specific education.

*Second:* Examination, diagnosis and advisory service.

*Third:* Definite treatment.

In some instances the traveling clinics are definitely equipped to function along two of these lines, in a few instances along all three. When treatment is given, the clinic manifestly must function, also, along diagnostic and educational lines.

The traveling clinics whose purpose is primarily educational in character have resorted to practically every known modern educational expedient, including formal lectures, informal talks, personal advice, pamphlets, leaflets, exhibits, stereopticon views and motion pictures.

One of the most interesting of these clinics is the Child Welfare Special which began its career on the 11th of July, 1919, in Morgan County, Illinois. This clinic had its origin in the needs of the rural child, and the desire to give the country child the health and medical facilities heretofore accessible only to the city child, and to bring home by personal contact the lessons of child conservation.

Although children were examined at this clinic (100 to 150 weekly in the counties first visited), these examinations were merely incidental. The main purpose of the clinic was to demonstrate by means of the examination of the children the need of periodical medical examination and the method of meeting this need, and to stimulate and aid in the organization of permanent child welfare work in the community. The examination of each child usually took about twenty minutes. During the examination the doctor would discuss each point with the attending parent, who at its conclusion was given copies of appropriate pamphlets published by the Children's Bureau, as well as a record of the child's physical condition and any written recommendations the doctor might have to make. If any defects were found, the parents were urged to have them attended to promptly by their family physician. As the clinic was not for clinical purposes, but wholly educational in character, sick children were rejected and referred either to a physician or to another clinic.

Since this clinic was primarily an educational clinic, the examination of children was reinforced by other means of bringing home the lesson of child welfare work. The Special carried an exhibit consisting of posters, charts, panels and miniature models of a few household utensils used to show good ways to bathe, clothe, and feed young children. This exhibit was set up in a nearby waiting room and put in charge of a member of the hostess committee. Now and again the doctor and nurse talked informally to the waiting mothers, using the exhibit or charts to illustrate the points they made. The Special also carried moving picture films and stereopticon slides which were shown at prearranged evening meetings.

Another interesting experiment of recent date, which illustrates the use of the motor truck for educational purposes along health lines is the Social Hygiene Field Car. This experiment is being carried out under the auspices of the American Social Hygiene Association, the American Red Cross, and the United States Public Health Service, and state and municipal boards of health. Its purpose is to carry on an educational campaign throughout rural districts through the use of moving pictures, stereomoto-graph slides, and other exhibits, regarding the ravages of venereal diseases and methods to combat them. Special women's and men's lecture films are used for the women's and men's meetings, respectively. In this campaign, school houses, churches, lodge rooms, and other available

meeting places are, so far as possible, used for the lectures.

An interesting modification of the motor truck whose purpose is primarily educational, is the Health on Wheels Truck of the New York State Department of Health, which is especially equipped to show health films at any remote locality, whether or not suitable halls or electric current are available. The body of this truck is so designed that it can be used as a temporary infant welfare station, as a miniature traveling laboratory, as a means of transporting x-ray and other apparatus for clinical work and for other purposes. A somewhat detailed description of the construction and equipment of this car will be given in a later section of this paper.

For the purpose of weighing and measuring children and rendering advisory service, the Public Welfare Committee of Montreal conducts a traveling baby clinic. Ordinarily the patients are limited to twenty-four months and under. This clinic, the first of its kind in Canada, was put into the field in the autumn of 1917, and since then close upon 1,000 children have been examined. This healthmobile completed a three weeks' itinerary through rural Quebec, examining both children and babies, and conducting a public health exhibit at the rural fairs.

An illustration of the second type of clinic, that is, the clinic whose primary purpose is diagnostic rather than educational, is the occasional tuberculosis clinic which was successfully initiated by the Tuberculosis Committee of the New York State Charities Aid Association. This was a traveling clinic not in the sense that it utilized the motor truck in order to get about from place to place, but in the sense that the clinics had no fixed location and were held only occasionally and at varying intervals. For this reason, perhaps, their discussion should not form part of this paper. However, I speak of them briefly here. In the work of establishing tuberculosis dispensaries in the cities of New York State, the fact was brought out that a real need of facilities for the examination of the lung existed in small communities and rural districts where there was no dispensary and often not even a resident physician with special training and experience in the diagnosis of tuberculosis, especially in its early stages. To meet this need, traveling dispensaries were established which furnished expert medical examination to remote communities at irregular and rather long intervals. They served, however, not only to furnish this much needed

diagnostic service (treatment was never rendered), but also to demonstrate the need of tuberculosis hospitals where they did not already exist, to promote the increased use of existing hospitals, and to bring to light the conditions that promoted the spread of the disease, and thereby made possible effective methods of preventing it. These clinics have grown in number until now they are held under the auspices of the New York State Department of Health and the New York State Charities Aid Association jointly and separately, and under the auspices of local communities who have established them on their own initiative.

The Health Clinic of the Chicago Tuberculosis Institute, which serves a similar purpose, works on a definite schedule, covering about forty different towns each month at specified times. In mild weather the clinics are held in the healthmobile itself; in cold weather they are held at waiting places, usually a schoolhouse or church. An average of two hours is spent at each place, during which period from ten to fifteen patients are seen.

A so-called diagnostic traveling clinic on a somewhat more ambitious scale, though not employing a motor truck as a means of transportation, is that recently inaugurated by the New York State Department of Health. This clinic is diversified in character, is in session at given points for a week or more, devotes its attention to a variety of diseases, and is manned by skilled visiting specialists.

The third type of clinic is that which, while doing diagnostic work, also goes further when necessary, and gives treatment as well. Obviously, the traveling treatment clinic has marked limitations. It has, however, proved a success in the treatment of teeth and trachoma, as witness the Mobile Dental Units of Nassau County, New York, conducted under the auspices of the Junior Red Cross, and the Traveling Trachoma Clinic conducted by the United States Public Health Service Bureau for the purpose of operating on cases of trachoma.

Nassau County (Long Island, New York) has many villages and townships but no large cities. "The greatest need for the health of the children," writes Mrs. Marion Willetts Brower, chairman of the Nassau County Chapter of the Junior Red Cross, "lay in the inability of doing follow-up work after the required New York State medical inspection revealed alarming physical defects among pupils in the common schools. On further examination it was found that the greatest trouble was the condition



of the teeth. Ninety per cent of the 25,000 children of Nassau County needed immediate attention. With the records of the draft boards still fresh in everyone's mind, it was decided that this was the best end at which to attack the problem." Finding it impossible to get the children to local dentists, it was decided to take the Junior Red Cross dentist to the children. A Ford delivery car was bought and equipped with portable dental apparatus. Such was its success that before the end of the school year six dentists were employed, two dental cars were placed in the field, and one dentist was paid mileage for driving his own car.

A word as to the details of running one of these clinics. The clinic visits each school upon definite written application by its superintendent. A date is fixed and when the car arrives, the equipment is carried into the schoolhouse and the examinations begin. Defects are jotted down on a mouth chart, made out in duplicate. One of these charts is retained by the Chapter and the other is sent by the child to his home, accompanied by a consent card, worded as follows:

"TO THE PARENTS OF. ....

Your child..... needs dental attention. This is the time to have the small cavities filled to prevent future loss of teeth. If you have a regular dentist, will you please take your child to have these cavities filled while most of them are small? If you have no regular dentist and wish them taken care of in school, at a cost charge, by the Junior Red Cross Dentist, please sign the attached card and return to the teacher."

"TO THE JR. RED CROSS DENTIST:

You are hereby authorized to do any dental work for my child ..... that you may deem necessary, said charge in advance or upon completion of the work."

Following the noon hour of the first day, signed consent cards and money begin to come back and the dentist starts his work. A record of the work done each day is made out on the "day sheet" which is mailed daily by each dentist to the executive secretary of the Junior Red Cross, at the Chapter House. When the dentist completes his stay at a given school the executive secretary of the Chapter compiles from the day sheets and cash received a statement of the work done and the financial transactions, and sends it to the principal to be countersigned. The local dentists have been very cordial and have found that the educational work of the clinic has filled their waiting rooms.

A somewhat more ambitious scheme was the two motor clinics put into the field by the Nova Scotia Provincial Branch of the Canadian Red Cross Society. They trav-



eled throughout the Province of Nova Scotia during the months of July and August of this year. Each clinic consisted of motor trucks, motor ambulances and touring cars. These vehicles conveyed four medical specialists, dentists, trained nurses, and Red Cross representatives, and the equipment of a ten to twelve bed hospital to be set up quickly in schoolhouses or other suitable buildings. The purpose of these clinics was not only to teach the laws of health and assist in the improvement of local health conditions, but also in remote places to make medical inspections, treat children and those afflicted with tuberculosis, and do dental work, particularly for children and emergency cases. The main effort was directed toward impressing on people the importance of having everyone, especially the children, frequently visited by the local physician, in order that disease and its effects might be dealt with in their early incipency. Only persons who were unable to pay were treated at these clinics unless a special request was made by the family physician.

### Construction and Equipment of Motor Truck Clinics

Manifestly, it is out of the question to describe in detail the construction and equipment of the various kinds of motor truck clinics. The equipment naturally depends very largely upon the purpose of the clinic. Some conception of their construction and equipment may, however, be obtained from a brief description of two or three types.

The Federal Children's Bureau, under whose auspices the work of the Child Welfare Special, to which reference has already been made, was conducted, submits the following description of this truck:

The truck is modeled very closely upon the dispensary truck used by the Chicago Tuberculosis Institute. The body of the car is constructed of wood, painted white on the inside and battleship gray on the outside. The words "Child Welfare Special" are lettered in blue and white on each side of the car. The truck is roomy enough for a conference room and two dressing rooms. The conference room is nine and a half feet long, six feet wide, and six feet four inches high in the center. This room has four windows on each side, high enough to be out of reach of prying eyes, yet admitting sufficient light for daytime examinations. The driver's cab, which is entirely enclosed in glass, can be reached from the conference room by a sliding door; with the shades drawn it forms one dressing room. The open-end gates of the car, provided with double folding doors and heavy curtains that fit into grooves, form a second dressing room. When a mother enters one

of the rooms, she has the exclusive use of it until the child has been undressed, examined, and dressed again.

Most of the equipment of the truck is built in. A 15-gallon water tank, tucked away over the driver's cab, is connected by faucet with a stationary washstand in the conference room, which in turn is connected with a drain to the outside. The examining table and the linen lockers are built over the wheel housing, an arrangement which saves space and improves the appearance of the car. A scale for babies and older children is carried in an especially built trunk. There is enough storage space for 2,000 publications, a full set of exhibit material, a balopticon with several boxes of slides, two rolls of moving picture film, several dozen charts for lecture purposes, cot, bedding and cooking utensils for three persons, a large supply of sheets and muslin squares, and all the other equipment necessary for conducting a children's health conference.

Two systems of lighting, one for a 110-volt current that can be taken from a nearby public building, and the other for a six-volt current taken from the truck's own batteries, furnish excellent illumination for night work. Two electric heaters have recently been installed for use on cool days. Weather strips have been put on the cab to keep out wind and rain, and a tarpaulin made to fit over the rear doors keeps out the dust.

Arrangements have been made for the staff to sleep on the Special—the doctor on an army cot in the conference room, the nurse on a similar cot in the rear dressing room, and the chauffeur on the driver's seat, which was constructed to serve as a bed.

The Social Hygiene Field Car now touring North Carolina is a truck weighing a ton and a half. It contains a complete motion picture equipment capable of throwing a picture one hundred feet either indoors or out in the open. It also has a darkening apparatus for dimming schoolhouses, churches or other places. A 3,000-watt, 60-volt, 46-ampere generator and a lighting plant to supply power not only for the moving picture machine motor, but also light for the lecture hall.

The healthmobile of the New York State Department of Health consists of a three-quarter ton motor truck chassis upon which is superimposed a body about the size and shape of an ordinary motor ambulance. The truck has a generator independent of the auto engine for producing electric current, a storage battery and moving picture machine, and a sectional screen which is fastened to the strongly reinforced roof of the truck. The New York State Department of Health furnished the following interesting details as to how the healthmobile gets into action once it reaches its exhibition ground:

When the healthmobile reaches the locality where it is

desired to give an exhibition, the lower half of the rear door is let down so that it virtually forms an extension floor, while the top half is raised so that it extends out beyond the roof, forming a shelter for anyone standing on the tailboard. The electric generator outfit, which burns either kerosene or gasoline, is then started, in order that the storage batteries may be fully charged while the picture machine is being set up. The latter is transported in the body of the truck in a trunk especially designed for the purpose. The apparatus is raised to the roof and set up at the forward end of the truck, while a folding screen is bolted into vertical position at the rear end of the roof. In order to obtain a greater focal distance, this screen has been made so that it can be slid outward from the rear end for a distance of from two to four feet. While the machine might equally well be placed in the body of the truck and the screen braced on the ground, the location on the roof has the added advantage that the picture can be seen from a greater distance.

The dental units used by the Nassau County Junior Red Cross are Ford delivery cars. On their bodies appear the legend: "Junior Red Cross Dental Education Car." They are equipped with Archer Manufacturing Company's Child's Prophylactic Chair. Although its chair can be carried from the car into the school building by the dentist and the janitor of the school, it is absolutely steady and durable. Instruments, the instrument cases, foot engine, sterilizer, and a small stand which holds the instrument case and the sterilizer made up the remainder of the portable equipment when the clinics were first inaugurated. As the work progressed, a Waugh x-ray machine with a Coolidge tube was added to good effect. In schools that were not equipped with electricity a small kerosene stove with a sauce pan served as a suitable substitute for the electric sterilizer.

### Preparing the Way for Effective Action

In most instances the motor clinic has to depend on advanced publicity and organization for real effectiveness. The kinds of advanced work needed depend, of course, upon the nature and scope of the campaign.

As indicative of the advance work required, let us consider the work done preliminary to the visit of the Child Welfare Special.

This clinic went only on the invitation of the state board of health, thereby insuring the cooperation of local agencies, such as the county medical society, the county board of education, the board of trade, women's clubs, and kindred organizations. These bodies assisted in mapping out the itinerary, arranging for meetings to explain

the need for vigorous manhood and womanhood, as well as the purpose of the clinic. Committees were organized in the larger towns and chairmen and hostesses in the smaller settlements. These committees were responsible for receiving the Special and its personnel, securing publicity, an appropriate stopping place for the clinic, the attendance of special groups and the foreign born, making appointments with families desiring conferences, providing motor service for speakers, and other activities. An advance agent usually preceded the arrival of the clinic by about two weeks, and assisted in the organization of these committees and their work. This agent carried with her material for the newspapers, printed instructions for the committees, copies of announcements for the ministers, and posters advertising the Special. In each community she visited the local officers, editors, physicians, ministers, farm advisers, county demonstrators, representative citizens, business men, and social agencies to explain the purpose of the clinic.

### What of Results?

In one of the reports submitted to the Federal Children's Bureau early in the career of the Child Welfare Special, Dr. Francis Sage Bradley observes:

The Special has the distinct advantage of at once gripping public interest as none of the previous work could do. This may seem spectacular from the professional standpoint, but it gets results. It is believed that the ground can be covered better by the Special than in any other way; that its better equipment will make far better results than any method tried to date; that its usefulness is directly in proportion to the ability of the physician in charge to make the public realize that she is merely demonstrating the need of periodic examinations and a method of accomplishing the same; that she bears in mind the fact that the examination is merely an incident and not the object of the Special, and that its more important function is to stimulate and aid in the organization of permanent follow-up work by the community, and that she does not scorn to take advantage of the dramatic element of an appeal from the government at this psychological time.

Miss Janet M. Gesiter, R.N., who had an unusual opportunity to observe the work of this clinic, offers this testimony:

\* \* \* the cordiality of the response, the awakened interest, the new efforts to conserve childhood that are following in the wake of the Special are, in my opinion, well worth the money and trouble expended. Its very bulk and unusualness challenge attention instantly, and

when its mission becomes known it enlists the hearty cooperation of the entire community. The Special is a very tangible evidence of Uncle Sam's interest in his children—it has a dramatic appeal that is easily capitalized.

Here are a few samples of some of the specific results of the influence of this particular project. A latent medical society was stimulated to work for a county nurse; a group of farmers were impelled to seek information as to the meaning of child welfare work; a council of miners were moved to raise about \$800 toward the support of a community nurse; a baby clinic previously thought of bloomed into actuality; milk clinics for undernourished school children were encouraged; local physicians were swamped with children's work following the visit of the Special. Cleveland testifies that its Children's Special compelled people in all walks of life to think about child conservation. The mother who had hitherto shunned the Baby Welfare Center was compelled by the very attractiveness of the Mobile Clinic to resort to it whenever her baby needed attention. Connecticut, too, felt that the chief accomplishment of its baby Special was the interest it aroused in child welfare in hitherto apathetic and indifferent communities.

Regarding the work of the traveling tuberculosis clinic of the Washington Tuberculosis Association, Dr. R. J. Cary, consulting physician, writes under date of September 20, 1920.

In the beginning we were somewhat doubtful as to the results that might be obtained from such an experiment in this state, but in looking over the results we have been convinced that it was one of the most practical methods of reaching the smaller communities, and as a result of our experience with the Traveling Clinic and Exhibit, the Medical Service of the State Association was started the first of January, 1920, and up to the present time forty-three clinics have been held in various parts of the state outside of the cities of Seattle, Spokane, Tacoma, and Everett, ten of which may be designated as permanent.

The September issue of the *Social Hygiene Bulletin* reports that an unofficial count taken during the first week's tour of the social hygiene field car through North Carolina shows that 6,100 men, women, and children saw the moving pictures, stereomograph slides, and other exhibits. Preliminary reports indicate that a goodly number of persons infected with venereal diseases or fearing that they were infected, applied to local physicians and clinics, as well as to the members of the staff of the field car, for information and treatment.



As to the work of the traveling clinic which the Bureau of Venereal Diseases of the Florida State Department of Health sent throughout the state, particularly to turpentine and lumber camps and other labor centers where treatment facilities were not provided, Dr. Lorin A. Greene, director of the State Bureau, reports that "the plan is working out splendidly and in the location where the clinic is now operating we have under treatment a very large number of venereal cases, most of which could not have been reached in any other way."

Here is a summary of the work done by the Junior Red Cross Mobile Dental Clinic from September, 1919 to June, 1920:

No. of schools worked in.....	40
Pupils receiving dental attention .....	2591
Number of sittings .....	4825
First molars extracted .....	853
Other extractions .....	2100
Treatments .....	423
Prophylaxis .....	2058
Fillings .....	8707
Root fillings .....	69
Approximate hours of service rendered.....	3114
Charge for work done .....	\$9543.30

In beginning this work it was found necessary in many instances to relieve pain and clean up many badly abscessed mouths. This year the aim of these clinics will be to care first for the children in the lower grades by beginning a systematic program of preventive work.

One further bit of testimony in closing. When Dr. George E. Vincent, president of the International Health Board, visited Nova Scotia a little over a month ago for the purpose of evaluating the work of the Red Cross Caravan clinics, as the Nova Scotians picturesquely characterize their multiple unit motor truck clinic, as a factor in public health education, he expressed his opinion concerning the work likely to be accomplished by traveling clinics of this character in these words:

The mobile clinics which have recently been in the field in Nova Scotia under Red Cross auspices represent a suggestive and valuable demonstration of the kind of service which a modern health center can render. The undertaking has a number of important aspects. It has rendered service to thousands of individuals. It has impressed communities with the meaning of modern diagnostic methods. It has emphasized the preventive aspect of medicine. It has strengthened the position of practitioners throughout Nova Scotia, and has created a public opinion which ought to result in substantial appropriations to the public health service of the Province.

There is no reason why every corner of Nova Scotia should not have regular access to diagnostic laboratories and various forms of service. This would mean not a



supplanting of the present medical profession, but the opening up of new possibilities and a reinterpretation of the practice of private physicians.

The Province is to be heartily congratulated upon the success of the caravans, the influence of which will be felt throughout the continent. Nova Scotia, with its homogeneous and intelligent population, is in a position to make a striking demonstration of a thoroughly efficient public health service working in close relation with the medical profession and with private agencies.

In this brief paper I have not attempted an evaluation of the traveling clinic as an instrument for promoting the public health. At best, this is a difficult task, and the subject is important enough to warrant a separate paper. Whether its advantages outweigh its disadvantages when examined in relationship to particular purposes, must, until a greater volume of data is available, remain the responsibility of those in charge of particular projects.

THE CHAIR: Before we take up the discussion of this paper, there is a matter of importance to come before this session. It is a rule that each section elects its officers for the coming meeting. There is an Out-Patient Committee or Committee on Out-Patient work, of the Association, and it was thought best that the officers of that committee be the officers of the section, and last year at Cincinnati, action was taken accordingly. For the coming year we will take that course if that is the sense of this meeting. Do I hear any objections? I do not. Mr. Weber's paper is now open for discussion.

MR. WARDEN: After having seen something of the work of clinics in an educational way, I want to say two things in regard to them. Some of you have seen Dr. Goddard's recent book and have learned something of the results with the 1,700,000 recruits taken for the Army. The conclusion drawn is that the average intelligence is that of a child of about 13 years. The average intelligence of persons coming to a clinic for instruction is less, it probably runs not over 11 or 12 years. What is the lesson to be drawn? Those who have been teachers can readily see that any instruction, to be effective, anything that will actually meet the needs of those people, must be concrete rather than abstract, must be such as is given to children of that age in our public schools. Some of our clinics have done this very well, but in general the criticism can be made that the educational work is rather too abstract to be actually comprehended by the people who are in attendance at those clinics. And the second matter is this; it is one thing to present a subject and to convince

your audience of the absolute truth of what you say; it is another to furnish the dynamics, the spiritual force which will enable them to go out and actually do something.

MR. WEBER: I think that Dr. Stiles, of the Montreal Clinic, is here and has some interesting data to give us on our work.

DR. STILES: I was connected with the first traveling clinic inaugurated in Montreal in the fall of 1917. The speaker has spoken of the work we are doing in the sense of our advisory service, our weighing, measuring and probably, to a less extent, of the treatment phase. We have found in our work in Montreal and its environs, and likewise during this last summer in our eastern townships through the medium of this traveling agency, the impelling good that the thing is capable of. We have secured publicity, newspaper publicity. We have gotten the message of health over to a people who would not otherwise have been in our grasp. They have been attracted by the novelty, the originality of the affair, to come to us and with their presence we have automatically put over the preventive phase of medicine. The speaker has gone into that very carefully. Some of the statistics have been very alarming. Most of us had the idea that the city child was in a far lower physical plane of efficiency than was the rural child. One of the speakers early in the evening mentioned the fact that the rural child is handicapped to a greater extent than the city child. Our experience has been the same with the child in the Province of Quebec, over which our experience extends, that the child in the Province is more physically unfit than the city child, and the reason is that they have not learned the first idea of preventive medicine or what it means. They start at the wrong end, and that applies even to their public health bodies, where they do exist, the Women's Club, etc. In the most progressive town in an Eastern township we found the women's organizations there focusing their attention on a sanitarium campaign; they were getting the Government to stand back of a \$200,000 proposition, and it was our good fortune to interview the Provincial Treasurer and I think we gave him one little thought. We told him that he could conscientiously spend the \$200,000, or at least a portion of it, in a preventive campaign for opening up windows. People talk about the good air of the country, but the kiddies in the country never get a chance to breathe it. The windows are barricaded summer and winter, spring and

fall, so that if the children don't get sickness naturally, unnatural means are taken and the child has the usual children's diseases. Our campaign was strongly supported by the township press and I am sure that the seeds of the gospel of good health have been sown this past summer and that good results will accrue. I will not burden you too much with any statistics. A group of children in the City of Sherbrooke, which is possibly our most progressive city in the eastern townships, a group averaging 13 to 24 months of age, the average undersize of this group was found to be one and four-fifths inches; the average underweight of that group was 33.7 ounces. There is a group of apparently healthy children. The mothers brought these children to us for a weighing and measuring diagnosis. They would not have brought these children had they thought they were underweight or poor specimens. Some of the extremes ran, in point of undersize from four and one-half inches to an underweight of 152 ounces. The physical defects noted we shall not go into too thoroughly. They were enlarged tonsils—we know all these things, but the great point was the great prevalence of community disease. We found that a goodly percentage of those children had whooping cough. Down in Sherbrooke they have a peculiar way of tackling the public health problem. They are in the very rudiments of the game, and some think they are not in the game at all. There is no compulsory notification of communicable disease. If that is done by a progressive M. D., automatically the health department in the city taxes that family \$5 to have the house disinfected, with the result that they use every pressure on a progressive physician to curtail that necessary notification. There were whole streets down there in September of this present year full of whooping cough; we have seen kiddies in the five and six weeks' stage with their sequelae. That condition is awful, and all the theory of hygiene that they teach in schools is not getting over.

THE CHAIR: This session will stand adjourned.

## AMERICAN HOSPITAL ASSOCIATION.

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, October 5, 1920, 8:00 P. M.

### SECTION ON HOSPITAL ADMINISTRATION

Chairman: Dr. R. B. Seem, Presiding

Secretary: Dr. A. C. Bachmeyer

CHAIRMAN SEEM: Inasmuch as I have several other duties which are requiring my personal attention at this time, I would be glad to entertain a motion for the election of a substitute chairman for this evening.

DR. L. H. BURLINGHAM: Mr. Chairman, I move that the Secretary, Dr. Bachmeyer, be appointed Chairman for this meeting. Motion carried.

DR. BACHMEYER: Our first speaker of the evening is a man widely known throughout not only the west, but throughout all Canada. He will speak to you this evening on the subject of "Some Essential Factors in Efficient Hospital Administration."

DR. M. T. MACEACHERN: Mr. Chairman, ladies and gentleman: I have nothing new for you this evening, but I am going to cover some of the old, everyday facts with which we are dealing in our hospital administration.

Our meetings should all be characterized by something practical, and something which we can all take back to our respective fields, and I have tried to adhere to that as much as possible.

The question we are to decide is, after all, how best can we serve the patient. That is to say, we must not forget the patient and our service to the patient in all our deliberations, no matter what they are. After all, it is the patient who is our objective and our perspective, and you hospital administrators must take a stock of yourselves and analyze your work and ask yourselves, "Are you giving to the patient the best service which you can; the service which the patient deserves?" If you do so, you will fulfill your mission as hospital administrators, and serve humanity and the community and your country.

Hospital Administration today is becoming of more and more importance. It is a science and something real. It used to be a sort of perspective function which could be

exercised by anybody, but today it requires natural adaptability, study, experience, and above all, I would emphasize, a liking for the work, because the path is not strewn with roses, but on the contrary, it is full of bumps and unpleasantness at times.

The first point tonight which I wanted to take up with you is that of "Organization—Hospital Organization."

I have a few slides here which I will now show you which will emphasize the points I wish to make.

DR. BACHMEYER: Doctor MacEachern has taken a longer time for his interesting address than was perhaps intended, but I am sure we will all forgive him for that.

I will now ask Mr. Pliny O. Clark, Superintendent of the Presbyterian Hospital, Denver, Colorado, to open the discussion.

MR. PLINY O. CLARK: Mr. Chairman and fellow members of the Hospital Association: Doctor MacEachern was entirely too unassuming. I wish he might have told us of some of the other splendid things which he is doing in Vancouver, of which doubtless a good many of you know. One of the things into which he is injecting the spirit of this fine hospital is the general health work of the city. His staff and himself are directing some of the most important health organization work which is being done there; a very splendid thing for the Hospital administrators to do, because it brings right back to the hospital a large share of the interest which it needs in his community.

The doctor spoke of publicity as an important thing for the administrators to consider. It is undoubtedly something which we should consider very seriously, and give more thought to than we have.

And yet, back of all this splendid talk there kept running over and over in my mind the fact that there are two types of administrators—the extremes perhaps; one who is dominant everywhere, dipping into everything, start the engines, cook a good roast, if necessary (perhaps he never does it) but he is everywhere. Details are his delight. He controls the situation by dominating it. The other is that type of leader which delegates each action to his assistants; gives them something definite to do and loads them up; makes them efficient, puts responsibility clearly up to them, and prepares them for the field of their own, and helps distribute their lives; perhaps makes them over.

Of these men, I think you will all agree, the latter type is the type which is to be the more desired.

DR. BACHMEYER: I regret because of the lateness of the hour, that we cannot have any further discussion on this excellent paper.

DR. BACHMEYER: The next paper is entitled "The Selection and Organization of the Hospital Personnel," by Dr. C. G. Parnall, Medical Superintendent and Director of the University Hospital, at the University of Michigan, at Ann Arbor.

DR. C. G. PARNALL: I might say at the outset that I am going to say something which I had hoped would be elaborated upon in the discussion. However, I foresee that the discussion must necessarily be limited, and I trust, therefore, you will not misunderstand me.

The administration of American hospitals has long been known to be almost in a class for inefficiency with the governmental organization of the average American municipality. That the same amount of scandal has not characterized the hospital as has disgraced the record of the cities is not due to cleaner methods but rather to the cleaner men who have guided the devious destinies of our hospitals. While improvement has been marked, it is still a fact that hospitals in this country are, generally speaking, poorly organized and indifferently administered.

The survey of the American College of Surgeons in its standardization program shows that only a relatively small percentage of hospitals the country over are giving to patients the service to which they are rightly entitled. It is fortunate for some of us that the inquiry did not extend into all departments of the hospital; otherwise I suspect that the percentage of acceptable institutions would be very small indeed. Perhaps it is fortunate, too, for us that hospital patients seldom are aware of our shortcomings. To date they have not been in a position to know what the hospital should furnish and consequently to demand the highest type of service. With no pressure on the demand for service it is not surprising that the supply has not been forthcoming. So few hospitals are in a position to guarantee to their patients the best that modern science and business methods can give that people are not inclined to hold the hospital responsible for matters which it should have entirely within its control. If the patient, or his "administrators or assigns," discovers that he has been badly cared for, a somewhat unlikely event, he is inclined to hold the med-



ical attendant responsible for any lack of skill or medical knowledge. The hospital authorities also, when danger threatens, fall back upon the ancient, if not honorable, recourse of "passing the buck."

### Inefficiency of Hospitals Recognized

Professional service in hospitals and administrative functions have been so widely separated that it is difficult indeed to institute reforms bringing the professional conduct of members of the medical staff under control. Proper medical service is not generally regarded as the responsibility of the hospital to the patients. It would seem that most of the difficulty lies in the failure of average governing bodies of hospitals to appreciate the real function of the institutions they administer. Public trusts are often accepted without any adequate idea of the obligations they impose and expediency many times leads men and women to adopt decisions which the exercise of their judgment would surely warn them to avoid. Thus we find highly successful men of affairs as members of hospital boards concurring in the employment of utterly inefficient and incapable officers and employees who would not be considered for a moment in their own business organizations. Such men are usually more or less handicapped by the popular faith in the degree of doctor of medicine.

With executives incapable of controlling their medical staffs and with members of the medical staff, through influence or otherwise, exercising what practically amounts to control over the hospital board, the result has been a hit or miss method of conducting the affairs of the average hospital. The sufferer, as always, has been the public. It is not to be inferred that all hospitals are poorly administered. There are in the country a large number of institutions governed by groups of men and women who are insisting that the hospital shall stand for the very best in its organization and in its service. The fact remains, nevertheless, that boards of a high order of collective ability and efficiency are the comparative exceptions.

As far as the selection of governing boards is concerned it is difficult to offer constructive suggestions. It is not feasible nor is it advisable to command the services of men of sufficient caliber by paying the market value for their services. If controlling boards of municipal and state hospitals were so selected politics

would inevitably be more in evidence than under the present plan. So that, practically, boards made up of interested people of the right type who serve without pay, are no doubt to continue as the governing heads of hospitals and similar institutions. In general it is probably true that boards composed of small numbers functionate more efficiently than large ones. Members selected for their real interest in the hospital and its affairs are of more value than those whose selection has been made on the basis of their social, financial, or political standing.

The way, then, to approach the problem of improving the organization of hospitals is by the process of education of the members of hospital boards. This, of course, is a large program and will be one of slow accomplishment. However, there is no better way. Obviously it is impossible for the individual members of hospital boards to keep so closely in touch with hospital affairs that they are each cognizant of all the details of management. Further it is quite unnecessary that they should be.

The most important step in the improvement of present conditions is to convince hospital boards of the necessity of employing as their deputized agents (in the capacity of executives) men and women of high character and thorough training. Usually as members of hospital boards will be found men with business experience so that it is comparatively easy to convince them that a good executive means a successfully organized and administered hospital. While funds may be low and difficult to obtain, it never pays to employ incompetent persons in places of responsibility and one reason that hospitals are chronically hard up is that their boards have not had the foresight to engage superintendents who could make the available money go farthest and who were able to show the need to those who, being convinced, are quite willing to provide either privately or from public funds.

The real leadership of the hospital should be in the executive. The superintendency of many hospitals is even now an exalted clerkship and not so very exalted at that. The reason that more competent people are not engaged in hospital administration is that little incentive is offered. Many drift into the work through accident and remain because they are unfitted to assume any large responsibility. As a result of the lack of opportunity offered to hospital administrators there is a shortage which is so notable that the Rockefeller Foundation

has taken occasion recently to call together a group of representative hospital people to discuss the problem and to secure suggestions regarding the establishment of training centers for hospital executives. Before attempting to train executives, however, it would be well to establish clearly the essential qualifications of such persons and to suggest means of presenting inducements which would attract those who possess the necessary attributes.

### Some Qualifications for Hospital Executives

No discussion is ever carried far before the question as to whether the hospital administrator should be a physician or a layman is brought up. The hospital administrator who has not had a medical training is seriously handicapped, but no more seriously than is the medical man who lacks executive ability and business experience. Very few laymen are qualified to assume the direction, in any large way, of institutions caring for the sick or the insane. Most physicians are disqualified through the very nature of their work. Doctors are notoriously deficient in dealing with business problems. However, the chief function after all of the hospital is the care of the sick, and in order to appreciate the numerous problems connected with the professional care of patients, it is highly essential that the superintendent or other executive shall be a medically trained man. I know I shall not encounter unanimous support in this position but I say medically trained *man* advisedly. Trained nurses have proved comparatively satisfactory as executives, especially in small hospitals. At the same time I hold that except for very small hospital organizations a man is much more apt to be successful than a woman. I believe in high standards for nursing. I have taken occasion whenever possible to advocate the cause of the trained nurse and to secure proper recognition by the medical profession and the public at large of nursing as a profession, but I am convinced that the trained nurse has her limitations as a hospital chief executive. The reason for the almost universal employment of trained nurses as hospital executives has been simply that a higher quality of intelligence could be purchased for the money than could be secured in the services of men in the positions. Given the same degree of intelligence and the same training, however, a man is a more satisfactory executive than a woman. Men apparently

do not take kindly to the direction of their activities by women and as practically all physicians and a goodly part of the employees of a hospital are men, my position can be easily understood.

Returning to the question of medical training one cannot become at all familiar with the history of hospital administration in this country without recognizing the part taken by laymen as hospital organizers and executives. Among the leading hospital administrators one will find the names of many men who have not had medical training. Some of these men have not had a college education and yet it is entirely conceivable that they would have made excellent college presidents. This, however, is not intended as an argument against a college education. It must still be conceded that a college preparation is a highly essential requisite of the college president. In the same sense a medical training will not make a hospital administrator but in order to deal with the medical problems and with medical people (perhaps it would be more correct to say the medical problems including medical people) a man must have both medical training and experience if he is going to be responsible for the whole program of the hospital's activities.

Of course all this depends on what our conception of the hospital executive may be. Dr. Rufus Cole, in a splendid article in which he makes a plea for higher standards in medical teaching and research, states in effect that the arrangement of facilities and organization for carrying on the work of research should be undertaken by research men and not left to the superintendent of the hospital. "It would be just as sensible," says Dr. Cole, "to have a foreman of a machine shop design a laboratory for the department of physics as to have a hospital superintendent design a university hospital."

On the other hand, Dr. Edsall, in arguing the case for the better qualified administrator, states "The hospital administrator in hospitals connected with medical schools is of extreme importance in the proper development of medical education and medical research; in other words he is of very great importance to the future of medicine, for he can do as much as any one in the whole system to further or block the developments in the clinical branches especially. . . . It is of the utmost importance to medicine in general that the hospital administrator should have sympathy with and comprehension of the objects

and methods of medical education and medical research." How can one reconcile these apparently divergent views? This is easily done, for it seems that Dr. Cole's position is well taken if he has in mind the hospital executive of the past. Dr. Esdall, on the other hand, had in mind the administrator of the future. If one were to look for a man of the caliber for fulfilling Dr. Esdall's ideals, with but few notable exceptions, he would be compelled to go outside the hospital field. The introduction of new blood into the fraternity of hospital administrators in the way of well equipped medical men with vision of the possibilities of the hospital and experience in dealing with people will be beneficial. We need a new outlook, and inspiration doesn't always, as the term implies, come from within.

The hospital executive as previously indicated must be a man with the qualifications of leadership; he must have power to exercise authority; he must be big enough to exercise authority with discretion. He must be, in army parlance, the commanding officer, responsible, of course, to the body employing him and removable if he fails to accomplish his mission. Such a person must be compensated adequately both in opportunity and in money. While he may never expect to amass wealth, he should be paid as his responsibilities entitle him to emolument. In any field it must be recognized that "the laborer is worthy of his hire." If proper incentives are placed before young men in their medical careers there will be no difficulty whatever in securing high class medical executives including hospital administrators.

Although title may, perhaps, not be considered a matter of prime importance, it is unfortunate that the term "superintendent" is so generally used to designate the chief executive officer of a hospital. One ordinarily thinks of a superintendent as a more or less important foreman or, at most, a department head. As a dignified and definite title to apply to the executive head of a hospital, if he be vested with large discretionary powers and particularly if he be the medical administrator as well, the term "director" or "medical director" would seem more appropriate than "superintendent."

With the selection of the administrator the chief problem in the organization of the hospital has been solved. The same principles of obtaining competent personnel and paying the price will have to be observed. So often, even in large hospitals, there is apparently no effort to



organize the officers and employees, defining their duties and checking their work. The cook, the laundry maids, the pupil nurses and heads of alleged departments all report to the superintendent. As likely as not the superintendent boasts of his knowledge of the details of all branches of the hospital work. As long as he is willing to assume responsibility for everybody's job, his subordinates are willing that he should. The executive becomes tied to his desk, he sees the little things but not the big ones, and his officers and employees develop no initiative or enthusiasm. Probably the most satisfactory method of organizing the administrative activities of the hospital is to place at the head of each distinct one or of a group of related ones, a well qualified person and hold him accountable for the entire conduct of his department, giving him authority to develop plans and methods, only guiding his efforts by frequent personal interviews and by close observation of his results. Poor service and lack of accomplishment of the work laid out should not be tolerated. The subordinate who is "just fair" or "pretty good" is the most deadly drag on any organization. The competent executive must, therefore, be quite as capable of judging when to "fire" as well as when to hire.

Among the important subordinates in the hospital personnel, depending on the size of the organization, are the assistant executive, who should be all that his chief may be except for experience and maturity; the business manager, who if competent will relieve the head of the hospital of an immense amount of routine detail; the superintendent of nurses; the dietitian; the housekeeper; and the chief mechanic. Each should be a master in his or her domain. Thoroughly reliable persons in these positions should be well paid.

For the guidance of hospital trustees and executives it would be well to formulate schedules indicating rates of compensation for the administrator and his subordinates. A fair compensation will attract a competent man or woman but who will agree as to what the actual figures should be? Here, it would seem, is a proper and practical problem for a committee of this Association to consider. The wide difference in emolument for officers throughout the hospitals of the country indicates that there is no general understanding of the comparative value of personal services in institutions and an authoritative statement from those qualified to give opinions



would be a first step in establishing standards and scales which would create an interest in administrative medicine and tend to popularize it as a career with those who will be needed in this rapidly enlarging field.

DR. BACHMEYER: I will call upon Dr. Winford H. Smith, Superintendent of the Johns Hopkins Hospital, Baltimore, Maryland, to open the discussion.

DR. W. H. SMITH: I wish to emphasize the fact that if the executive officer of a hospital is to be a successful administrator, he must have so many qualifications that I hesitate to enumerate them, but above all, he must have the capacity of co-ordination. In my opinion, his function is that particularly of a co-ordinator of the various activities of the institution.

Undoubtedly the success of any executive depends very largely upon his ability to select competent assistants and competent heads of departments, and having selected such, if he is to be successful in his organization, I quite agree with Doctor Parnall that authority should be delegated to the fullest extent—at least to the fullest extent of his capacity, and if their capacity is not sufficient to enable them to share the responsibility of their position, then the selection is wrongly made.

There is one practice which is to a certain extent prevalent in a great many institutions and large institutions, which it seems to me is all wrong, and that is where the policy of the Board of Trustees does not permit of the presence of the Superintendent at the Board meetings. He is an Executive Officer of the Board of Trustees, and if he is competent to hold that position, he should be advising them and enlightening them, and if such is the case, what could be more absurd than the custom which prevails in many of our larger American hospitals which bars the Superintendent from the meetings of the Executive Board or the Board of Trustees, or however the governing body may be known.

DR. BACHMEYER: I regret, because of the lateness of the hour that we cannot have any further discussion on this paper of Dr. Parnall's. The next paper is entitled, "Keeping Up with Administrative Progress," by Dr. Harold W. Hersey, Superintendent New Haven, Conn.

DR. HERSEY: During the past five or six years business activities of all kinds have been conducted under abnormal conditions. Briefly, these conditions include inflated wages, unsettled labor conditions, scarcity of manufactured products, uncertainty in their delivery, readjustments in social

conditions, and a continuous shrinkage in the value of the dollar. The position of the business executive has in consequence been one of extreme tension, requiring constant vigil and unwonted caution.

The hospital administrator has had his full share of these difficulties. Indeed, with the less favorable financial conditions under which he "carries on," his burden has at times been extreme. There is an old saying that "misery loves company," and while the position of executive is usually of one's own choosing and should in no wise be likened unto a bed of thorns, the deduction is that in difficult times one should consult with his confreres and profit by their experience. How many of the various business executives may be considered as confreres and how much we may profit by their observations is one of the purposes of this paper to discuss.

Dean Johnson of the New York University School of Commerce states that business may be divided into three classes: "*first*, the production and sale of goods—this kind of business is commonly known as industry and embraces all kinds of manufacturing; *second*, the purchase and sale of commodities (by commodities is meant anything which has value and is therefore salable); *third*, the purchase and sale of services, whether the services of human beings or the uses of material things."

Primarily, the object of all hospitals is to render to those incapacitated by illness or injury, a highly specialized type of service. Economically, the purpose of the hospital is to restore to the community an individual as nearly physically sound as possible, in the shortest period. It is the thoroughness of this restoration, in consideration of the time expended, which denotes the degree of efficiency of the hospital. Since the hospital deals with service, it falls into the third group of business.

No duties are more exacting than those of service, and in none is the organization more subject to criticism. It is necessary for the executive to avail himself of every method and every opportunity to check up his organization and to see that it ranks high in efficiency and production when compared with the standards set by representative organizations elsewhere. In order to make these comparisons it is necessary that definite standards of comparison be available, that one visualize the comparisons, and keep in touch with the business progress of the outside world.

Efficient hospital service requires of the executive

broad knowledge and deep understanding of both medicine and business. The officer must be a planner and an organizer. He must possess a working knowledge of mechanical and electrical engineering, heating, lighting, and refrigeration. He should be a thorough accountant, a careful and conscientious buyer, a systematic storekeeper, and have a thorough knowledge of modern laundry, kitchen, and house management. But above all, he must deliver from his organization medical and surgical service of a high order, conforming in every way with accepted standards.

### Medical and Surgical Organization Progressing

Let us first turn our attention to the medical and surgical organization. Medicine itself has made rapid progress and the ideas of today are not the ideas of yesterday. Medical and surgical technique have improved, specialties have developed, diagnostic and therapeutic measures have advanced, preventive medicine and public health have become established. In the field of nursing and the training of nurses a large problem has arisen, for modern medicine requires more careful attention to nursing detail, while the long hours and menial tasks formerly expected of nurses no longer seem just. Coupled with the fact that other occupations and professions offer definite hours and congenial surroundings with early remuneration and in consequence fewer applicants are received by the training schools, the nursing problem is requiring the best efforts of both hospital executives and superintendents of nursing. We hear many solutions of the nursing problem and much discussion. In my judgment, any readjustment tending to lower the nursing standards will fail in accomplishment. In order to attract a desirable type of young women into the training schools, we must offer something better than at present, be this fewer hours of duty, more congenial surroundings, or a more highly specialized training. I believe that before many years a university degree for nurses will be available at many hospitals through affiliation with universities.

Much has been written about hospital standardization and it has been widely discussed. Much more should be written and greater discussion encouraged, for the medical organizations, although vastly improved, are in many instances a long way from perfect. An excellent organization exists in the American College of Surgeons and the work contributed by them has done much to

stimulate many hospitals to renewed efforts. Organized at Washington, D. C., in 1913, among the purposes being "the betterment of medical education and of the clinical practice of medicine," it has already accomplished much that is beneficial and has accumulated valuable data. Its chief effort for the hospitals has been to establish a minimum standard that every hospital may hope to attain. Briefly, this standard calls for an organized staff of reputable, competent physicians and surgeons. Monthly meetings should be held at which the clinical work of the staff, both successful and unsuccessful, is openly discussed and analyzed, with a view to preventing a repetition of mistakes and profiting by the success of others. Accurate and complete records should be filed and adequate x-ray and clinical laboratories maintained. It is interesting to note that a survey made by this college in 1918 and 1919 shows that of 671 general hospitals of 100 or more beds in the United States and Canada only 198 meet the minimum standard.

It should be the duty of every hospital executive constantly to bring before his board the necessity of conforming with these minimum requirements and to relinquish his effort in no wise until the medical organization is so founded. The hospital which falls short of its duty to its patients in guaranteeing efficient and modern treatment cannot hope to attain high rank or to hold itself above reproach.

So much for the medical and surgical organization. Let us now consider the business organization. Within the past decade it has been recognized that business is a science and that its phenomenon could be explained by certain laws, just as the phenomenon of physics and chemistry could be explained by certain laws. The universities finally awoke to the fact that it was just as essential to graduate students well grounded in business principles as it was to train young men in the fundamentals of arts, language, law and medicine. At present schools of business administration are established in many of the universities, among them the University of Harvard, Pennsylvania, Michigan, Illinois, New York, and others. Unfortunately for most of us, these schools have developed too late for us to avail ourselves of the splendid training thus offered; but this fact merely means that our efforts to keep in touch with business progress and administration must be along well organized lines, always with a definite purpose in view.

How may such efforts be most productive? In my judgment there is no better way than by securing some well recognized course in business administration and devoting a definite period weekly to its study. Right here I wish to say a word of warning. In any reading of this sort there is much that is good and much that is of little value. To obtain the best results, recognized authorities should be consulted, men broad in mind and purpose associated with leading universities or institutions. There are many good courses on modern business. One of the best that I know of is the course of the Alexander Hamilton Institute. A few hours weekly spent in its reading cannot fail to stimulate any executive to a broader conception of business principles. It is fair to add that these volumes are in the offices of many of our leading industrial executives.

There is another reason why the hospital executive should make every effort to keep in touch with business methods, and outside business in particular. As the older men retire from the executive boards of the hospital, the tendency is more and more to replace them by young, energetic business men. In order to convince them that new steps in the hospital organization should be carried out, the hospital executive must present his facts in convincing hole-proof statements. He can do this only by a thorough knowledge of business principles.

### Comparisons of Other Institutions Efficacious

Admitting, therefore, that a knowledge of outside business is absolutely essential, let us now proceed a step further and consider a large industrial plant. During the past few years I have been fortunate enough to visit several. The procedure in all well organized plants is much the same. You enter a clean, orderly corridor and immediately are met by an attendant who offers service. Telephonic communication is established with the executive you are to visit and a messenger shows you to the office. After a brief statement of the departments in which you are interested, you are personally conducted through the shops, power plant, storerooms, accounting, and statistical departments. You make mental note of one thing after another. Later, in the seclusion of your own office, you find that many of their methods may be applied to your own organization. You recall, for example, that each line of pipe from their power plant was of a distinguishing color, that their organization



perhaps exceeded yours in courtesy or promptitude, or that their statistical department contained data valuable to you. This same method of visiting and comparing should be carried out at frequent intervals in other industries, and is applicable to large hotels, restaurants, dining halls, and commercial laundries.

Last year I made a tour of the Middle West and of Eastern Canada, visiting, during that survey, nineteen of the leading hospitals, asking numerous questions (as any of the nineteen executives will agree) and collecting valuable data. My reception was most cordial in every instance, and the material obtained has been of tremendous value to me during the past year.

In the American Hospital Association is one of the greatest powers for good available to one interested in hospital administration. It is the privilege of everyone in charge of a hospital to become an active member of this organization and the alert executive will avail himself of this privilege. In no way can the executive better keep abreast of the times than by attendance at such meetings. It should be the duty of the hospital superintendent to attend these annual conferences. It should be the duty of the executive board to send their superintendent to these meetings, to insist upon attendance during the full meeting and to see that the expenses for attendance are defrayed by the hospital. The amount expended will be returned to the hospital ten-fold by increased efficiency and energy. Just as the executive should represent the institution at the conference of his association, the superintendent of nurses should attend the conference of the National League of Nursing Education and the dietitian should attend the meeting of the American Dietetic Association.

In New York and in many other large cities there is frequently a hotel men's conference and exhibit. Since hotel management has many problems in common with hospital management, much may be gained by attendance at these exhibits.

For many years a group of representative hospital executives have met occasionally during the year in Boston and after dinner a round-table for the discussion of hospital problems has been held. A similar organization has met in New York. These afford one of the best methods of getting together and similar meetings should produce results in any part of the country. The state organization is on a similar plan. In Connecticut



we have recently organized the Connecticut Hospital Association and expect to accomplish much this coming winter.

No executive can decide wisely unless he knows the actual conditions in his plant. He should, therefore, inspect all his departments at frequent intervals and should have daily reports from and conferences with the head of each department. This cooperation may be carried further by monthly meetings between the resident staff and the executive staff for discussion of purely administrative problems. With the resident system, many of the men have advanced from service as intern to assistant resident or resident and these young men look at the hospital with the eye of an executive. Their criticisms are just and their arguments sound. I have found such meetings of great benefit. At the Massachusetts General Hospital, before the war, we had a fair sized executive staff and during the winter held weekly administrative conferences. The discussions were of great value to all.

### Scientific Principles of Business Employed

More and more the business world has come to represent its dealings by the graphic method or charting. By charts one is able to lay his facts before others in a convincing manner and this is the real purpose of collecting data. The large industries chart their departmental wages, their total pay roll, their production, the amount of stock on hand, the stock withdrawn, the turnover in labor and many other things. Charting is used by all banking concerns and by all statistical bureaus. It is absolutely essential for every man to become interested in financial conditions throughout the world and not only to understand the various types of charts but to be able to chart his own business transactions. At the New Haven Hospital we have recently been charting some of our daily procedures, such as admission and discharges of patients, operations, number of nurses of various groups on and off duty, monthly expenditures, receipts, and the like. Charting is applicable to almost any phase of hospital administration, and we expect to work out a small number of charts which will require but a few minutes time daily and put us in closer contact with conditions.

Emerson in his "Twelve Principles of Efficiency" gives as the third principle, "competent counsel," and states that competent counsel is necessarily derived from many

minds. It is sometimes advisable when a department is not running smoothly to call in and consult an expert in the particular branch concerned. The value of this is two-fold. It allows the executive to view the situation through other eyes and lends weight in presenting arguments to his administrative board. On my last visit to Baltimore, Dr. Smith informed me that he had just completed a survey of his laundry, by a laundry expert, with the result that they had installed new machinery and had, consequently, increased the efficiency and reduced the pay roll. Through the courtesy of a large industrial plant, the New Haven Hospital has recently had a survey made by experts from the various departments of that highly efficient organization. The report submitted contained the opinions and recommendations of men highly trained in accounting, business efficiency, engineering, store-keeping, and hotel management. It is too early yet to state what the result of such a report will be, but it contains many recommendations of value and I anticipate that much good may result. It is quite possible that other hospitals could arrange for a similar survey to their advantage. Certain it is that I have always found industrial executives willing and anxious to cooperate in every possible way and I believe that all hospitals would profit by a closer affiliation with leading industrial plants.

The various agricultural colleges and chambers of commerce publish daily or weekly market bulletins stating the receipt of market commodities and the prevailing prices. These bulletins may be obtained at little or no expense and are of value to the buyer in securing advantageous prices. The Hospital Bureau of Standards and Supplies of New York affords another excellent opportunity for the buyer to keep in touch with current prices and to purchase at an advantage. The purpose of this organization, to quote from the organization agreement, is "co-operation in establishing uniform standards as to quality and kind of supplies—and of purchasing the same in accordance with definite specifications under continuing or other general agreements." It is quite possible that if similar organizations were established in other parts of the country, similar beneficial results would accrue.

Certain statistics are required in every hospital in order to keep in touch with the various sources of income and of expenditure. Most hospitals have these statistics in various forms. Most institutions issue an annual report containing valuable data. These reports and sta-

tistics should be and are exchanged and studied by the various executives. And yet in collecting hospital forms and data, what a variety of methods, shapes, sizes, and colors one encounters. Each hospital has worked out its own system in accordance with its needs. No two accounting systems will be exactly alike, some being on one basis, some on another. Does it not seem odd that with hospitals conducted so nearly on similar lines, no more uniform systems of statistics and accounts are available? How much greater benefit would result, and how much greater would be the ease and satisfaction in comparison, if a group of hospitals, similar in purpose and size, would standardize their accounting systems and statistical forms and exchange weekly statements. I know of no way in which more valuable data could be obtained.

Although the board of directors of the average hospital has seen its annual deficit steadily mounting during the past few years, the more conservative have viewed with skepticism the advisability of a public appeal for funds, or a drive as it is commonly called. I do not share this feeling and see no reason why the support of the hospitals should fall upon a few. It should be as much the duty of the citizens to support the hospitals as it is to maintain the public schools, public libraries, the highways and water systems. Every citizen should put aside annually a sum for hospital support, as he would for society or club dues. The weekly expenditure of the average family for soda and moving pictures, if totaled and proportioned to the hospitals, would maintain modern institutions of the highest order. Such a contribution would work no hardship. The average citizen, however, would never entertain such a proposition, even should he have assurance that the chances were 100 to 1 that he would shortly become a patient in the hospital. He would gamble on the one chance and let someone else bear the burden, trusting to fortune that an institution of high order would be available, should he need it. I believe that the state of Iowa had legislation enacted by which a small amount per person is set aside from its taxes to care for the indigent poor. Other states may have a similar arrangement. I am not familiar with its workings. If there are executives present from Iowa it would be interesting to learn its advantages and disadvantages.

Last year the directors of the New Haven Hospital conducted an intensive drive of one week's duration. The response of the New Haven public was most generous

and \$233,000 was realized. The expenses of the campaign were approximately \$10,500. In our own case, therefore, the hospital drive has proved both feasible and beneficial. It should be carefully considered elsewhere.

Some hospitals conduct courses for those wishing to train as hospital executives. The advantage to an instructor in conducting classes is recognized, for in order to present new facts of interest to his students an instructor must know and review his subject at frequent intervals. Added to this is the stimulus derived from the questions of the students. A six months course was formerly given at the Massachusetts General Hospital. Two applicants were accepted for each class and spent their time observing and doing actual work in different departments. This afforded an excellent training for the applicants, usually young women, and most of them are today holding desirable positions throughout the country as hospital executives.

I now turn to the part literature should play in this subject. The magazines useful to the hospital executive may be considered in three classes.

*Medical magazines.* Foremost in hospital administration is the fact that we are dealing with a highly organized specialty, the care of the sick. There are numerous well recognized medical publications and I will not attempt to suggest those most beneficial. Each executive should choose the one best fitted for his guidance. The tendency of most of us is to treat medical literature slightly and to devote our time to numerous other problems, but we should at no time lose sight of the high ideals with which we are associated and should steadily increase our knowledge thereof.

*Magazines of hospital administration.* The two principal magazines edited in the United States on hospital administration are too well known to require much comment. The progressive executive can ill afford to be without one or the other, or both. There is also a valuable Canadian and a British publication. These could be made more useful if the publishers wrote annually to the subscribers asking in what manner they could best be served during the ensuing year.

*Magazines of business administration.* There are numerous good publications of business administration. Those I have found most useful are *System*, *Industrial Management*, and *Factory*. All contain timely articles. Many banks issue a weekly or monthly letter, such as

the pamphlet issued by the National City Bank of New York, summarizing financial conditions. *The Magazine of Wall Street* is also of considerable value. In Massachusetts no one can maintain financial serenity without constant reference to the *Boston News Bureau*. There are many similar publications in other cities, which require but a few minutes attention daily.

The books dealing strictly with hospitals and their management are few. The two most recent contributions which have come to my attention are "Dispensaries, Their Management and Development," by Michael M. Davis, Jr., and Andrew R. Warner, M.D., and "The American Hospital of the Twentieth Century," by Edward R. Stevens. There are doubtless others.

Finally, a word as to the library of the hospital executive. Each executive must determine his own requirements. It is usually admitted that a library does not represent the reading done by its owner, but enables him to consult competent authority when in doubt. In the September number of *THE MODERN HOSPITAL* are two articles of unusual interest. One is by S. S. Goldwater, M.D., entitled "Self-Education for Hospital Executives." The other is an editorial stating in brief that the Modern Hospital Publishing Company is about to publish a series of practical handbooks and has secured Dr. S. S. Goldwater as editor-in-chief. Both of these are progressive steps capable of much good. I shall not attempt here to outline a library but merely wish to mention a few books I believe the library should contain. As stated elsewhere, there should be a thorough business course. In addition I would suggest:

"The Organization, Construction and Management of Hospitals," Ochsner & Sturm. (While not recent, this is still very valuable.)

"The Modern Hospital," Hornsby & Schmidt.

"Accounts," William M. Cole, A.M.

"Elements of Accounting," Joseph J. Klein.

"Cost Accounting for Institutions," William Morse Cole, A.M.

"Corporation Finance," E. S. Mead, Ph.D.

"The Executive and His Control of Men," Enoch B. Gown.

"The Principles of Scientific Management," Frederick Winslow Taylor.

"Twelve Principles of Efficiency," Harrington Emerson.

"Personal Efficiency," Harrington Emerson.

"Production Factors in Cost Accounting and Works Management," A. Hamilton Church.

"Graphic Methods for Presenting Facts," Willard C. Brinton.

"Men Who Are Making America," B. C. Forbes.

"Purchasing," C. S. Rindsfoss.

"Modern Business Law," Edward W. Spencer.

"Hospital Accounting and Statistics," William V. S. Thorne.

"The American Hospital of the Twentieth Century," Edward R. Stevens.

"Dispensaries, Their Management and Development," Michael M. Davis, Jr., Ph.D., and Andrew R. Warner, M.D.

From the above paper we may draw the following conclusions:

*First.*—Business administration has made marked progress during the past decade and has lately been conducted under abnormal difficulties.

*Second.*—Hospital administration falls properly into the group of activities known as service.

*Third.*—In order to render to patients the service which they may reasonably expect, the hospital executive should (a) develop the medical and surgical organization in accordance with the organization of other recognized institutions and with particular reference to the suggestions of the American College of Surgeons; (b) develop a business organization in accordance with modern ideas of efficiency.

*Fourth.*—A persistent study of modern business principles should be made.

*Fifth.*—Other hospitals and industrial organizations should be frequently visited and studied.

*Sixth.*—Executives should join and take active part in medical, administrative, and civic associations.

*Seventh.*—Combined local activities are of great value among hospital executives.

*Eighth.*—Daily reports from and consultations with departmental heads, supplemented by personal inspection of departments, is essential.

*Ninth.*—A practical knowledge of graphic methods of presentation should be acquired.

*Tenth.*—Competent counsel should be consulted when necessary.

*Eleventh.*—The information from statistical bureaus should be available.

*Twelfth.*—Every effort should be made by the administrative board to stabilize the hospital finances.

*Thirteenth.*—The systematic reading of publications dealing with medical and administrative problems is essential.

*Fourteenth.*—A program of self-education should be outlined and an administrative library of recognized authorities acquired.

In conclusion, may I say that I realize the above program necessitates considerable reading, but by a systematic arrangement of hours ample time will be found after regular duties for study and essential recreation.

DR. BACHMEYER: I would like now to call upon Doctor H. M. Pollock, to discuss this paper.



DR. POLLOCK: Doctor Hersey made the point that we should try to develop a medical and surgical organization of the hospital with particular reference to the suggestions of the American College of Surgeons.

We have been trying to put this over for some time, and we have had some difficulty with the staff in doing so, in the matter of records, but since the American College of Surgeons came out with the minimum conditions, we have had no further difficulty.

Dr. Hersey brought out the point of visiting other hospitals, and particularly the copying of the method of the industrial firms. I want to bring out one more point. I think many of us feel that when we see a salesman we are wasting time. I personally would dislike very much indeed to see salesmen cease to visit my hospital. Most of the things I have learned concerning certain things, how to judge cotton, how to select the laundry machinery and how to choose meats and so forth, have come to me from salesmen, and I feel very much indebted to them and I am not feeling that I am wasting the time that I spend with the salesmen who come to see us, but on the other hand I feel that it is time that is really well spent, because I believe that in no other way can we so easily keep abreast of the times.

THE CHAIRMAN: The meeting will stand adjourned.

## AMERICAN HOSPITAL ASSOCIATION

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, October 6, 1920, 10 A. M.

President Howland in the Chair.

THE CHAIR: The meeting will please come to order. Mr. Borden, Chairman of the Committee on Constitution and By-Laws, has an announcement to make.

MR. RICHARD BORDEN: Several amendments to the Constitution have been proposed, either in papers or by announcement, and I want to call attention to a provision of the Constitution, which is that the committee on constitution and rules shall consider and report on all proposed amendments to the constitution and by-laws. Naturally, before making any report, your committee should carefully consider the proposed amendments, because it does not pay to trivially meddle with the constitution that has been adopted. Unfortunately, as frequently happens, it has been impossible to have a meeting of the committee at this convention. It would be necessary, in order to have any amendments acted upon, to present it tomorrow. Some of the proposed amendments propose a complete change in policy, as to certain methods which have been carried on for a good many years in this Association. One member of the committee would not feel at liberty to make a report upon that fundamental change of policy which should carry any weight with the voting members of the Association. To illustrate, one of the proposed amendments is that the nominating committee, a very important committee, should be elected by the convention, rather than appointed by the President. There are a good many reasons for the adoption of this amendment; there are a good many reasons against it, one which I might suggest being that for years the policy now in force under the constitution has been successfully carried on. What should be the recommendation with regard to this amendment, of course, I do not know. It takes more time than a couple of days' consideration, it seems to me, to formulate an opinion on such an important proposition. Heretofore it has been the custom of the committee on constitution and by-laws to receive suggestions by correspondence before the meeting of the Association, then either to have a

meeting of the committee or, if that were impossible, to discuss the proposed amendments by correspondence, and then, when the session convened, to seek the opinion of men and women whose opinion was of value on the proposed amendment. That having been done, to appear before the convention with recommendations as to the proposed amendment. It seems to me that that is a policy which should be continued and that it is very desirable in the future, if any member of the organization, of the Association, thinks that the constitution should be improved, to take the time in advance at least to communicate with the committee on constitution and by-laws. Now I have been through this matter with the proponents of the various amendments which have been suggested, and, with their consent, it seems to the committee desirable that no action should be taken with regard to any of the proposed amendments at this session, but that the matter be referred to the next committee on constitution and by-laws so that a competent report can be made before the matter is suggested to the convention for action.

THE CHAIR: You remember your President was instructed to appoint two committees, one of five members to consider the remarks which I made in opening the convention and also the recommendations made in the report of the trustees and of the Executive Secretary. I wish to announce the following Committee: Dr. MacEachern, Mr. Springer, Mrs. Eitel, Dr. Munger and Miss Kingston. We will now proceed to the first paper of the morning, "Community Funds for Maintenance and Capital Expenditures," by Mr. Pliny O. Clark, Superintendent of the Presbyterian Hospital, Denver, Colorado.

MR. CLARK: During the World War it was not a difficult matter to secure financial aid for the great war philanthropies. This was not always true of local charities, unless it was possible to show that in some way by supporting them the well-being of "our boys at the front" was being conserved, and then usually it was possible to obtain only a meager sum for maintenance; building programs and new work necessarily being pigeon-holed for a better day.

It was predicted that following the war every charitable, as well as philanthropic, organization not only would be able easily to provide for its own maintenance; but could proceed with needed improvements. And was not the reasoning sound? For were there not thousands who had learned the "joy of giving" for the first time, when

they gave during the war? And would not these, continuing their benefactions, greatly augment the sums contributed by the regular philanthropists?

The war ended, we all rejoiced, and began to readjust ourselves to new conditions, saying, "Well, now we can do some of those things we should have done some time ago; reduce the maintenance debt, or provide new equipment and buildings." There were many attempts and of various kinds, and, sad to relate, many failures. In consequence, the most necessary work has been curtailed or abandoned entirely, while new work (such as new buildings) has usually been undertaken with an abbreviated plan, if at all. We finally concluded that there is a difference between the appeal of war's emergency and plain, matter of fact, every day business.

The former was somewhat vague, indefinite, appealing to our heart; we gave ungrudgingly, we wanted a part in the great work. But as for the associated charities, the general hospital, why! they are just a part of the family; they have gotten along so far; they can wait for a while. "I've given too much already"; anyhow, "I don't like their methods of doing business"; and "They do no real charity work, why should I be called upon to support them?" There may have been many other excuses, but for our present purpose they will be passed without comment.

Never before have our hospitals been so crowded, so many refused admission, so great a call for larger facilities.

The situation calls for serious consideration.

The subject of new buildings or capital expenditures is so closely related to maintenance, we must consider both in this presentation.

In this discussion we cannot expect to consider the many interesting sociological and allied economic questions, but must confine ourselves to thinking through the problem of how our so-called charitable institutions (included in which class are the larger part of our hospitals) shall be maintained and new work provided for by the community which they serve. Perhaps we would better call them social welfare agencies. Yet the very word charitable means something; it suggests ideals, a service for the love of that service, and not because of the hope of any material reward.

Yes, we mean all that charity (love) implies, and more, for these very institutions have come to be a part of the

health, the social, the economic life of a community, and as such have a right to *demand* the necessary support.

We are, you understand, considering the ideal institution, that one which with high ideals combines most scientific methods and a completely successful and modern business policy.

### Maintenance Differently Met

When there is a difference between expense and income in maintenance, it may be met by one or more of four ways: (1) by taxation, (2) by interest from an endowment fund, (3) by public or private subscription, or (4) by a legacy.

For capital expenditures by institutions under private control we really have but two principal sources from which to draw: (1) popular subscription and (2) the result of a legacy, although we may well suppose the time will come when capital expenditures may be provided for by taxation.

#### *Maintenance by Taxation:*

The manner in which the State of Pennsylvania has for years supported her private charitable institutions by taxation is classic. And from the system has doubtless come much of good, especially a freedom on the part of the institutions from worry in making ends meet as well as a certain systematizing of methods, scientific and financial. Perhaps the stories of the political logrolling necessary to secure these grants were far fetched or untrue, yet we see few charitable institutions, especially the hospitals, seeking aid from their legislatures in other states.

We find, however, that states seem to be awaking to the fact that they owe something to those institutions in their midst which, without complaint, have for years carried a part of the state's own burden, and now are, in a more or less crude or inadequate manner, seeking to aid these hospitals by money grants.

In British Columbia the Vancouver General Hospital has been receiving Government aid on a sliding scale of from 43 cents to \$1.00 per day, when the cost was \$2.00. Speaking of the public's duty in this regard, Mr. R. S. Day of Victoria, B. C., recently said: "The public hospital exists for all. The burden of its support should fall on all, the wealthy should bear a higher share of the cost than the man of small means, for the strong should bear the burden of the weak."

In West Virginia certain hospitals are granted the use of a maximum amount as a fund upon which they may draw at the rate of \$1.50 per day for a charity case given care; a detailed report under oath being required from the superintendent in each case.

Some states leave the question to the counties, for instance, Illinois, Indiana, and Iowa.

Mere aid, and not complete support, by the state tends to injure rather than help a hospital, for many givers will brush aside an appeal for aid on the grounds that "the state takes care of the charity," not caring to consider the real fact that the state pays a very small portion of the cost.

If legislation by states in aid of hospitals, and similar institutions, is to be intelligently enacted, the makers of the laws should be advised by the hospitals themselves. This consideration suggests one of the principal reasons for the organization of state or provincial hospital associations.

Since it would be usurping a function of this Association's Committee on Legislation to review completely this subject here and make recommendations, we pass the subject of "Taxation for Maintenance," knowing the points of special worth will be emphasized by the one who is to lead in that phase of the discussion following.

#### *Community Funds for Maintenance by Popular Subscription:*

We now come to a most interesting part of this subject and one in which most of us feel we have had or would like to have some experience: appealing to the public for necessary maintenance funds.

In the average privately controlled hospital the annual deficit is not a large amount in dollars and cents, but gauged by the amount of worry caused the executive and the board of managers, it is a thing with which to reckon. Few hospital superintendents are employed to raise money; it is their business to manage the plant and they should not be obliged to secure funds with which to meet the deficit caused by policies laid down by the board itself. It is clearly the responsibility of the board to finance their philanthropic undertaking.

A comparatively small amount may be harder to raise than a large one. It is especially hard to meet the deficit in some places where the city or county has a hospital supported by taxation. In any case, the position of the



needy hospital must be perfectly clear, the public must be assured they are getting their money's worth when paying for a deficit. Obversely, many institutions are not doing the real work they should because of the fear of creating a deficit; when the terrible bugaboo is really not a deficit but a bill for services rendered and unpaid.

Ordinarily a deficit is met by a liberal endowment fund or by an appeal to the friends of the hospital, a list of whom is most carefully preserved and never by any chance given any other charity. The appeals to this list of friends are by personal solicitation by a member of the board or by letter from someone on the inside, or—and how often has this been the case?—by the executive herself or himself, in self-defense. By whatever method, the feat was accomplished by “making as good a showing as possible” for past work, and glowing promises for the future, if only——

It is true that many worthy and many unworthy money raising campaigns have succeeded since the war. But because there have been a few fakirs soliciting and because some campaigns have showed too large an expense account, because a campaign manager pocketed a big sum without an appreciable commensurate return, because the sum sought was not secured, the drive method has received a setback.

Quoting from a letter recently received from a recognized financial expert, the situation is thus viewed:

“We must recognize that because of the abnormal conditions prevailing during the past six years, the over-use and abuse of the intensive campaign from legitimate war purposes to many after-war irresponsible and unjustifiable pretexts has produced a reaction in the minds of the public which has temporarily hampered the conceded reliability of the intensive campaign as a weapon for civic improvement.

“Especially is this true of the so-called national campaign where organizations of all kinds have appealed to the public for funds to be used for general purposes without local application. This antipathy to national campaigns, however, is only temporary and its reaction is toward the giving of money for strictly local purposes where the citizen of a community feels he has done enough for the country at large and is ready to turn his attention to himself and his fellow citizens.”

The drive as an organized effort to raise money was probably first used by Mr. C. S. Ward in Y. M. C. A. work.

And we must agree that in the field of that splendid Association alone the drive has accomplished immeasurably important results. As a means of securing community funds it is undoubtedly a necessary and desirable part of our economic life. While it has probably been abused as a method, yet in the hands of capable and well trained experts it has many advantages, among them: increasing the clientele of the institution benefited; educating the public at large to the real purpose of the beneficiary as well as relieving good executives from financial worries and so increasing their efficiency. In addition it may be said that drives have aroused a sleeping public interest; have builded many permanent institutions; have educated the community served to a sense of responsibility for the welfare of society; have taught how to give; have corrected poor business methods used by charity organizations, through publicity; and have made innumerable friends for worthy causes.

Still it is likely the day of the so-called whirlwind drive, depending upon circus methods of arousing the giver, has passed, and in its stead has come the more thoroughly organized business of public solicitation founded on systematic accounting, sane business methods, and complete publicity. This method will likely continue in more or less favor for some time in the raising of funds, especially for capital expenditures.

As evidence of greater care and as a result of the war campaign needs, the National Information Bureau has been recently organized. This Bureau will not approve an organization unless it can subscribe to the following minimum standard of ten points:

1. Active and responsible governing body holding regular meetings, or other satisfactory form of administrative control.
2. A legitimate purpose with no avoidable duplication of the work of another efficiently managed organization.
3. Reasonable efficiency in conduct of work, management of institutions, etc., and reasonable adequacy of equipment for such work, both material and personal.
4. No solicitors on commission or other commission methods of raising money.
5. Non-use of the "remit or return" method of raising money by the sale of merchandise or tickets.
6. No entertainments for money-raising purposes, the expenses of which exceed 30 per cent of the gross proceeds.
7. Ethical methods of publicity, promotion, and solicitation of funds.
8. Agreement to consult and cooperate with the proper social agencies in local communities with reference to local progress and budgets.
9. Complete annual audited accounts prepared by a certified public accountant or trust company showing receipts and disbursements classified, and itemized in detail. New organizations which cannot

furnish such statement should submit a certified public accountant's statement that such a financial system has been established as will make the required financial accounting possible at close of prescribed period.

10. Itemized and classified annual budget estimate.

The purpose of this Bureau is briefly stated in a recent report: "a cooperative effort for the standardization of national, social, civic, and philanthropic work and the protection of the contributing public." It is supported by membership dues. It will not pass upon strictly local campaigns.

*Community Efforts:*

The day of individualistic effort is passing and the hospital is coming to see that its work is a dignified and necessary part of the economic life of the state, and as such has a right to expect commensurate recognition.

This new community consciousness on the part of hospitals seems to have grown out of participation by the hospitals' officers in the work of the social council of their town, observance of the far reaching effects of social work by the visiting nurses or social worker, or by an active participation in the management of another institution when doubling up during the war. It may have come because the amount required in any one year was small, and cooperation with another welfare agency in raising both budgets seemed desirable. However this new spirit may have come, it is arrived and ready for work.

A sign of this spirit is evident in the fact that many hospitals are participating in the organization of the federated plan of solicitation and disbursement of charitable funds through the scheme commonly known as the community chest. A still greater encouragement is the fact that in most instances the organization of the community chest was undertaken by the chamber of commerce. Such activity shows a new sense of responsibility on the part of business for its worthy charities.

The community chest is not the sole method available to meet maintenance expenses or even capital expenditures; but it does provide the avenue for the operation of that modern method, cooperation. It is economical in operation, tends to eliminate undesirable organizations, and increases the efficiency of those which are doing their best.

To learn how effective the community chest plan has been since the war, we addressed the secretaries of the commercial associations in one hundred of the leading

cities of the United States. Seventy-three replies were received, showing the following representative cities have already adopted this plan:

St. Paul	Houston
Cincinnati	South Bend
Rochester	Buffalo
Cleveland	Toledo
Detroit	Milwaukee
Kansas City	Louisville
Philadelphia	Baltimore
Dayton	Gloversville, N. Y.
Oklahoma City	Erie, Pa.
Plainfield, N. J.	

The following cities are considering it at present:

Atlanta	New Orleans
Nashville	Lincoln
Pueblo	Omaha
St. Louis	Salt Lake City
Utica	Syracuse
Columbus	Duluth
Denver	Bridgeport

In 1887 Denver organized a central collection plan which has since been known as the Denver Federation for Charity and Philanthropy; Cleveland organized a community chest before the war. Since then Cincinnati has perfected her most admirable plan, followed by others.

An increase in the number of subscribers is a point of worth. Parkersburg, W. Va., had 3,125 subscribers to its first campaign, or about six times the combined number supporting the individual objects previously. Youngstown, O., increased from 1,500 to 15,000, and in the last campaign to 20,000. In Rochester, N. Y., (population estimated 300,000) before there were about 5,000 subscribers; the first year of the chest showed 62,000, and this last one 66,000.

Cincinnati (population 401,426), with a federation and twenty-nine agencies participating, had 12,000 subscribers; in their 1920 chest, called the Cincinnati County Council, they had seventy agencies and 50,000 subscriptions. Erie, Pa., (population about 94,000) had a federation of twelve organizations with 4,000 subscribers; with the community chest they had 30,000 subscribers and secured enough in one year to care for all local philanthropies for nearly two years.

Cleveland, before the war, had a maximum of 8,800 contributors to a federation; the campaign of last November showed \$4,000,000 subscribed by about 160,000 people. Mr. Sherman G. Kingsley of the Welfare Federation found that in forty-three cities using the chest plan, 32 per cent of the entire population subscribed. He says, "the second, and perhaps greatest, result of these war chests was the achievement of solidarity. People laid

aside lesser considerations and worked together for greater things. It was a civic achievement, for both individuals and groups realized that, when they were thus working with one another, their community was functioning at its best, and that they were experiencing a satisfaction and a joy in service such as they had not known before."

To quote from the published survey by a committee of the Central Council of Welfare Agencies of St. Paul, we may show some of the proved results:

\* \* \* "Community chests have evidently been conducted so as to meet the approval of both the contributing public and the participating agencies."

\* \* \* "The community chest results in a situation in which the social needs of the community are more adequately and more efficiently provided for than under the old system of each agency working for itself."

In conclusion, the St. Paul committee stated some fundamental beliefs; \* \* \* "that while money raising is as important and perhaps the most immediately conspicuous feature of the community chest, its other aspects, namely, the opportunity afforded to improve standards of work, the tendency to make sure that the social needs of the community as a whole are squarely met, and the greater harmony and efficiency resulting from the close cooperation of the constituent agencies in the long run will prove to be the basic justification of the community chest plan."

Miss M. L. Keith, superintendent of the Rochester General Hospital, says: "Altogether, it is an educational process for the institution and for the public, and is bringing about a better mutual understanding of one another's problems. Long may the community chest prosper."

The community fund is a method well worth our consideration, even to the providing of funds for capital expenditures, though it will doubtless take longer to show the community responsibility in this latter regard than with respect to maintenance merely. In the smaller cities where the need for cooperation is not so apparent, independent methods will probably be used for some time.

#### *Independent Methods:*

For those institutions which cannot as yet join hands with a community chest or which may consider an independent drive unwise, and which are so local in character as to preclude national campaign methods, there are sev-

eral acceptable methods by which their deficits may be met.

First and foremost as essential to success with these as other hospitals, the work itself must be of the very highest standard. Second, advertise, educate, let the public know what is being done and what desirable thing could be done with additional funds.

As Mr. G. W. Olsen recently so well said in *The Modern Hospital*:† “We need a salesmanship that will sell the whole hospital idea to the people,” so that the people will be educated “to accept the needs of the hospital as their solemn obligation. If we can put that across, we will get the money; for people do pay their obligations, once they have been convinced they owe them.”

Having a public in full sympathy and yet without the community chest or a drive ready to supply the need, the most effective method of raising money is the personal solicitation of a selected list by the friends of the hospital. The results will need to be checked up, however, and the thing not allowed to drag on indefinitely. The superintendent might do well to ask these solicitors to take lunch with her daily until the campaign is finished.

Another method is to send letters attractively written, in fact gotten out by a publicity expert in close touch with hospital affairs, if possible. A good letter is often very effective, especially if followed by another clincher. Experts have declared that very large givers are more approachable through a letter than by a personal appeal, for in writing, the personal element is more nearly eliminated and the facts, as such, presented in their true light.

Various forms of membership in the hospital association is a method much used, and it has advantages other than the mere money return. It should make the member feel a sense of proprietorship, of responsibility, especially when some part of the business is left to decision by the membership at large. There are life, supporting, or annual forms, offered at from \$1.00 for annual to \$1,000.00 for life.

The indirect appeal should be noted as a method: entertainments, dances, church collections, lawn parties, tag days. This method possesses considerable educational value, but is prone to carry an expense budget often as high as 75 per cent of the receipts and to give the wealthy citizen the opportunity to discount his obligation by having contributed in a very small way anonymously through

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†Issue of August, 1920.



one of these sources. An article on the "Drive Industry" recently appearing in the *Saturday Evening Post* ridicules the use of tag days and similar methods, saying the public generally is tired of them.

Undoubtedly the press should be used as freely as possible in publicity, and may be of invaluable assistance in seeking public aid, and yet as a method of raising money, without other help, is of little practical value except in an emergency. Newspapers cannot be expected to carry for many days an appeal which has no real story value, unless the space is paid for as an advertisement, and then much of the intended punch may be lost or the expense outweigh the results.

#### *Private Benefactions:*

The discussion of funds for maintenance or capital expenditures would not be complete without a word concerning the private benefactor. This one is not affected by special appeals; he or she seeks out that which most interests him or her and gives in that place.

There is the possibility of seeking out such givers and by a studious cultivation of their acquaintance, secure their interest in a gift for the thing in which each of them believes. There are stories of the success of this or that most efficient executive; but if the truth were known there would doubtless be shown a benefactor whose pet hobby is that particular institution.

Some colleges and other institutions maintain financial agents to seek out those who prefer to give quietly and without display. The results vary, not always justifying the expense.

#### *Support by Legacies:*

Endowments, properly presented, would require an entire hour; but suffice it here to observe that many authorities now believe funds should be placed in trust in such a manner that the purpose originally designated may be changed if necessary, at least every ten years. This would certainly insure a more active use of our endowment funds and would obviate many objections now found to their use. It would make possible the revision of promises hastily made in securing the funds, such as the unlimited use of the bed so endowed.

If an institution expects any considerable support from this source, it must most certainly be worthy of it, for its every act will be carefully scrutinized by the maker of the

will and if it does not please, the provision stricken out. Still the goal of an adequate endowment fund is one to be eagerly sought and won.

### The Giver to Charity Has Inalienable Rights

Much, perhaps too much, has been written about the needs, methods and ways, but we hear very little about the *giver*.

The giver is the foundation of philanthropies, the support by which charity stands and, (shall we not say?) for whom these objects exist. For I take it, we all believe the individual has the right to an expression of kindness, brotherliness, helpfulness (call it what you may) coming from his best self to help in another's need.

The giver under primitive conditions could know all about his object of charity and help when and in the amount needed or according to his ability. But life is now so complicated it would be nearly impossible for one whose sole business it would be to give away money to know about all the worthy objects, to say nothing about the busy business man of the day, and then much less would he be able to place properly the funds given.

William H. Allen, in "Modern Philanthropy," has this to say for the giver:

"Heretofore we have thought more clearly of givers' duties than of givers' rights; that is one reason why givers themselves have not thought more consecutively of their own opportunities."

Among the rights of those who give time, thought, money, bounty, or taxes, the following should be recognized:

- "The right to give.
- The right to impose conditions.
- The right to stop giving.
- The right to refuse to give.
- The right to protection against importunity.
- The right to enjoy giving.
- The right to give where one's interest is.
- The right to give one's self with one's gift.
- The right to initiate.
- The right to give more ways than one.
- The right to freedom from self-imposed arbitrary restrictions.
- The right to give interest without giving money.
- The right to information before giving.
- The right to alternatives for giving.
- The right to know 100% about alternatives.
- The right to question.
- The right to give without hurting.
- The right to protection against disappointment when giving.
- The right to avoid gambling when giving.
- The right to one's money's worth of result for one's self and one's beneficiaries.
- The right to reports of results.
- The right to reports of work not done separated from work done.
- The right to know the world's experience in giving.

The right to expert, unprejudiced counsel.  
 The right to a public informed about giving.  
 The right to give secretly or anonymously.  
 The right to protection against indiscriminate praise.  
 The right to be dealt with sincerely.  
 The right to clearing houses of information about needs, appeals  
 and gifts.  
 The right to grow in understanding.  
 The right to know the relation of each benefaction to government."

Let us be more thoughtful of the giver.

We have tried in this very incomplete presentation to suggest that for maintenance and capital expenditures, funds may be obtained by means of taxation, by cooperative community effort, by independent campaigns, by several more or less effective minor methods and from an endowment fund; that a thoroughgoing, systematic business management is presupposed; that publicity is a prime essential; that cooperation will obtain better end results than independent action, that the executive force should administer and not be required to raise funds, that even the endowment fund needs more thought if it is to be thoroughly efficient; that to become efficient in securing necessary funds we must give more consideration to the giver and not look upon her or him as without rights; that undoubtedly a better day is dawning in the matter of the maintenance of hospitals and for funds for their capital expenditures.

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Buffalo	Kansas City
Cincinnati	Milwaukee
Cleveland	Oklahoma City
Dayton	Philadelphia
Detroit	South Bend
Gloversville, N. Y.	Rochester
Houston	St. Paul
Louisville	Toledo

Correspondence and reports from the secretaries of the Commercial Association in the following cities:

Albuquerque	Detroit
Atlanta	Duluth
Atlantic City	El Paso
Aurora, Ill.	Emporia, Kans.
Boise	Fort Wayne
Bridgeport	Gloversville, N. Y.
Buffalo	Grand Rapids
Charleston, S. C.	Harrisburg, Pa.
Chicago	Hartford, Conn.
Cleveland	Holyoke
Columbus	Houston
Crawfordsville, Ind.	Iowa City, Iowa
Dayton	Kansas City, Mo.
Denver	Helena, Montana
Des Moines	La Salle, Illinois

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 Little Rock, Ark.  
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 Memphis  
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 Manchester  
 Milwaukee  
 Minneapolis  
 Nashville  
 Newark, N. J.  
 New Orleans  
 New York  
 Norfolk, Va.  
 Oakland  
 Oklahoma City  
 Omaha  
 Ottumwa  
 Philadelphia  
 Pittsburgh

Portland, Maine  
 Pueblo  
 Reno  
 Rochester  
 Salt Lake City  
 Syracuse  
 South Bend  
 Spokane  
 St. Louis  
 St. Petersburg  
 Tacoma  
 Terre Haute  
 Topeka  
 Toledo  
 Waukegan  
 Wilmington  
 Tulsa  
 Utica  
 Wheeling  
 Worcester  
 (Also Cincinnati booklet)

THE CHAIR: You have heard this very important paper given by a man who knows whereof he speaks. It is so important a subject that instead of asking the discussers to discuss it as a whole, men were selected who were especially qualified to discuss phases. The first phase that we will hear of in the discussion is on "Money Obtained through Private Benefactors," by Dr. Frank Clare English, of St. Luke's Hospital, Cleveland.

DR. FRANK CLARE ENGLISH: Mr. Chairman, we have listened with interest and great profit to the thoughtful presentation of the subject, "Community Funds for Maintenance and Capital Expenditures."

DR. ENGLISH: In discussing the subject of raising money through private benefactions, I will assume a hypothetical case. Here is a hospital, in a populous community, actuated to a service for all the people by reason of humanitarian and religious influences. It has the sympathy and interest of the people because it does a work of real charity for the poor; provides healing for the well-to-do, who are permitted to pay their share of the cost; and renders a vital service to the community. Since no one is charged more than the cost of service, and many are given free and part pay service, it is not commercialized, and is therefore a benevolent institution.

We are all familiar with the cry for assistance, but the important matter is, how can we organize and conduct our hospitals so that they will receive a constant financial support for maintenance and development. If each of us were asked to answer that question would each not have three pertinent self-inquiries: First, do I believe in the institution I represent as worthy of my best efforts and the gifts of others? Second, do I believe myself capable

of securing its financial support? Third, to whom shall I present its needs for the help required? The real question, then, will be worthiness, need, interest, and supply. Upon the effective presentation of these points will depend success.

We all realize that private benefactions are desirable. They have a tendency to improve things generally. They have a bearing on the improvement of standards. They remove much exhaustive worry from the superintendent. They put heart into the trustees and staff. They stimulate others to give. They have proved good investments for the giver. When plentiful enough, they are better than tax funds, because they give the hospital the personal touch. Benefactions are as refreshing as the summer showers, and should produce the same response of life and thanksgiving.

What, then, are the principles and processes under which these blessings may be secured?

First, let us go into the psychological laboratory for a word known as want, then into the physical laboratory for a word known as attraction; we will join these words to make a new one, and call it want-attraction. We must not get frightened at a hyphenated word when it is well-born and well-formed, as this one is, for in my judgment the word want-attraction is the key-note of all success. True, it is not found in the dictionary, but it is located in the secret springs of successful careers. The thing itself, the hospital, must possess such attraction that people will want to use it when needed, and they will want their friends to have its benefits. They will want to support it as a place where help may be given to the helpless, as well as suitable care provided for the well-to-do. Indeed they will take pride in supporting an institution which renders the best service to the community. True, they may regard the hospital very much as some regard heaven—a delightful place to go, but they want to put it off as long as possible.

The thing that caused Andrew Carnegie to become interested in founding libraries and the development of colleges was his awakening to their benefits when a boy. He wanted information, knowledge, skill, and he sought their sources. Then he wanted other boys to have their advantages and turned his attention to libraries and colleges as the best attraction of a worth while service to humanity. In like manner the clinics and hospitals of southern and foreign countries, together with the scientific

work of medical and surgical experts, attracted the Rockefellers, and the wants of these philanthropists are finding expression in the development of medical and technical science. So also the Russell Sage Foundation was attracted by the cry of the children, and the want of its noble founder found a satisfaction in appointing millions and men to create better conditions for them.

Similar illustrations could be used of thousands. Seldom do men give to objects simply because they feel it their duty, or an obligation, or merely a desire to be known as a benefactor. Men must see something which attracts them.

This consideration leads me to say, second, that he who seeks benefactions must have a worthy cause. He must also have a strong conviction that he could not give his life to an object more worthy, and that his cause deserves the attention and support of the most influential. A hospital is organized as a healing and an educational institution, and must faithfully perform its mission. There will be no want-attraction if it is loose in administration, business management, or morals; or if the doctors and nurses are careless and neglectful of the sick.

The hospital that would attract the needed financial support will seek always to create and sustain favorable conditions. Such a hospital must have a board of trustees of unquestioned faith and integrity; a board which gives freely of its services and money; a board which looks after the interests of the hospital in every particular. It must have a medical and surgical staff of the highest grade, and nurses of the best training and character. It requires a superintendent who stands in the first class of administrators, who knows how to obtain and give results of one hundred per cent efficiency. Under these conditions the solicitor feels that he has something to represent.

### Hospital Must Sell Idea of Its Efficiency

In the third place, thorough knowledge of the hospital business and its operation is necessary to a successful representation. People want fresh facts about the organization and management; they want to know what it costs to run it, and where the money comes from; the number of pay patients, and whether they actually pay their share of the cost of service received; whether there are any real charity cases, and to what extent; what particular results are obtained; and the standing of the staff and nurses, with particular mention of specialists. If new buildings



are proposed, they want to know why they are needed, why they should be of certain capacity, whether the plans and cost are consistent, and whether all the money will be raised to complete the buildings without leaving a debt. The best judgment, tact, and skill of the representative will be required in selecting such facts and items as would naturally be of greatest interest to the one solicited.

Business men usually deal in per cents of the highest consistent rates, and when they invest in benevolent institutions they expect their money and service to bring one hundred per cent. It is our business to show them that we make every dollar bring one hundred cents worth, that we are one hundred per cent economical, and one hundred per cent efficient in all service from the janitor up to the highest officer.

May I now tread on sacred ground for an illustration. I say it reverently when I assert that from the pages of the Bible we may construct a manual of the very best salesmanship of vital worth. A study of its methods will show us how to present our cause effectively. Its spokesmen had thorough knowledge of the cause they represented. They believed tremendously in the subject-matter considered. They were tactful, skillful, and resourceful. They had different methods to reach different people. They assumed that their audience had intelligence and moral virtues. They believed they could move them to right and generous action. They began on an intellectual level with the man approached. In other words they knew their man, and knew what they wanted him to do, and had the knowledge and skill to get him to do it. They had vision and foresight of what should be accomplished, and had courage to undertake the most difficult tasks. In building enterprises they published the need, and urged that men should apply the means for the sake of humanity, and in loyalty and obedience to the Creator. Many other deductions could be made of helpful principles, which, when learned and put into practice, would give us a more certain success.

### Hospital Needs Must Be Made Definite

Fourthly, the hospital should be definite in its presentation of needs. Many a prospective giver has been lost because he knew there was no definite program. Definiteness and indefiniteness mark the dividing line between success and failure in anything. The giver must be approached with decisiveness and certainties. He must be

convinced that the hospital is a responsible institution, well organized and administered, and has a legitimate and definite purpose; that it is properly related to the social agencies; that it does not show too large an expense account in relation to service rendered; and that there is a certain record of results. He will also want to know whether the amount asked is sufficient to provide for the hospital for the next ten years or more to meet the increasing demands upon it for service.

Let us be concrete: the solicitor has in mind all the above facts relative to his institution. He knows why a maternity pavilion or a children's department is needed. If he follows the tramp's method, which is to stand at a man's door and say, "Give me something," "Give me a hand-out," he will receive a beggar's portion. But if he goes in a dignified and confident manner, and sits down, (or tries to sit down) with his prospect under favorable conditions, he can say, "We are under the necessity of building an orthopedic pavilion to care for scores of deformed and crippled children who are being turned away because we have no room. We have physicians and surgeons who are specialists with children and young people. They could give thousands the full use of their limbs if we could only provide room and care. It will require \$500,000 to provide a suitable building and equip it. We believe that all children have a right to be born healthy and strong, and that cripples should be made whole. Don't you think so?" That man is on the road to success because he knows what he wants and has pointed facts to say about it.

In the fifth place, there must be some organization for promotion. Getting people interested in a hospital is an art, the only thing that prevents it from being a science is that it cannot always be done the same way. The best way is the natural way, which always starts with the need. The service and the need become an attraction and a want. If we feel the attraction of the service we will want to supply its needs, and our wants will become so strong and we will so present it to others that they will also want to give their support.

Practically every hospital should organize its administration and work on a permanent basis of appeal. The character of its system of management and service should attract the attention and interest of the best citizens. Its service, needs, and opportunities should be kept in such an attractive manner before the public that it becomes the most potent appeal.

In the largest sense the hospital must discover its own resources, which essentially begin with its most intimate friends. Recently, as director of the hospital survey department, Interchurch World Movement, I discovered that many hospitals were not getting the money needed. Two probable reasons were the failure to aim at the highest grade of efficiency, and the constant leaning on outside and disinterested people for financial support. Many hospitals seemed to expect help to come in some miraculous way; they supposed that rich men and women ought to look them up, and bestow their gifts upon them, with very little effort on their part. But gifts coming in this way are very rare.

### Educational Methods Should Be Used

Sixthly, educational methods are most necessary. Nothing can take the place of wholesome publicity. Any efficient hospital has a right to have its work made public, for the better it is known the more readily funds will be found for it. Public interest can best be created and sustained by relating to it a series of outstanding cases of services rendered, and the recital of demands for further service that cannot be met for lack of equipment. Everybody seems to be interested in the remarkable cures of children and adults, cripples made whole and lives saved. The giving out of these facts is the very best propaganda.

Educational methods are of such a variety that it is unnecessary to catalogue them. Sometimes the story can be told in a half page or full page of a journal which is known to reach the constituency. An eight page folder, the size of an envelope, with a picture and a story on every page may be mailed to thousands who may be influenced; multigraphed letters, brief, pointed, and having a purpose may be carried direct to the multitudes on the mailing list; a two page folder telling what we are doing, what has been given for development, and what we need and plan to do, may frequently be sent out. The mailing list should be composed of carefully selected names. Do not shoot at random, aim at something, have people in mind who are able to help, do all that mortal man can do, then trust a beneficent Creator for divine favor. One thing to be remembered always, is that interest cannot be long sustained unless new elements are constantly entering and claiming attention. In approaching a period for campaigning the special publicity should be cumulative. Its force should not reach its height until the cam-

paign is started. Different methods, however, may be used for the quiet search for funds.

### Solicitation Should Be Skillful

Seventh, a successful solicitation is much to be desired. How to reach the large benefactor is a subject which scores of executives have studied. No rule can be set down, since every man must be approached differently. But a few observations may be made. One is that no appeal should be attempted until the solicitor has all possible information about the prospective giver; another is the propriety of meeting him through proper channels, and being presented by some one who can vouch for the integrity of the solicitor; another observation is, that many failures occur when success is near.

The greatest illustration of persistency is an event in the life of the founder of Christianity. On a memorable night He went into a well known garden for a mighty contest. Leaving all his followers outside the gate, except three most intimate friends, He entered; then after a period He went on alone, the record reads, "And going yet a little farther." It was at that point He won His victory, and it is at that point when we have gone to the utmost limits, that we shall win in every good and great undertaking. We are all engaged in worthy enterprises. Too often we have failed in our attempts because we did not hold on; we sometimes stopped just when a little more effort or persuasiveness would have brought the desired result. When all efforts seem to fail, when hope flickers like a dying ember, let faith fan it into a flame, "and going yet a little farther" over difficulties that seem insurmountable, and objections that appear insuperable, "going yet a little farther," when all others say it is no use, we will obtain the help needed. The cause is worthy and we should not fail.

It is important that nothing divert the solicitor from his purpose. He will meet objections, but must be prepared to answer them. A personal illustration may be apt here. When Mr. Andrew Carnegie gave me his second refusal of help for a new college building a few years ago, and stated his objections in writing, my cabinet advisors said, "The die is cast, it's no use." But the fact, that he had carefully stated his objections as reasons why he would not give, showed that the lamp was still burning, and I thought that

"As long as his lamp held out to burn  
His desire to give might return."

The following six days were spent with my executive committee. We gathered information by telegraph and other ways, and at the end of that period we prepared an answer which we believed was incontrovertible. The result was that a few days later, Mr. Carnegie answered this letter stating that he was glad to give us the half of a new college building. Other illustrations could easily be given.

Two bits of advice given me have been helpful. One benevolent millionaire admonished, "Never to ask for an amount out of modest proportion to the value of present property." This might be best for a college president; but it may not apply when the solicitor represents a hospital. Another said, "I will endorse evolutionary methods only, revolutionary methods won't go. You must build gradually and solidly."

I think we all agree that the best way to induce benefactions is to have an institution so well organized and conducted that it becomes an attraction, and the very strongest appeal within itself. When all these steps are carefully followed it requires little persuasion to secure many willing and cheerful supporters, and the larger gifts will come more readily. And finally, the personality of the financial solicitor will have unmeasured weight in securing results.

**THE CHAIR:** The speaker on the next phase of this subject, "Money Obtained from Public Taxation," needs no introduction by me; Mr. Howell Wright.

**HON. HOWELL WRIGHT:** Mr. President, ladies and gentlemen: Pliny Clark is usually more positive and profuse in his generalizations and his particulars than he has been in his discussion of Maintenance by Taxation. I expect that he thought he would open the door for discussion. Sometimes Mr. Clark opens only the side door, but this time he has opened the front door with a general invitation to walk in and seize the opportunity to discuss. Under Maintenance by Taxation he speaks of the subsidy system, that is, state, county, or city aid to so-called private public service hospitals. I find no reference here under this head to a subsidy for capital expenditure, or rather a subsidy for the maintenance of the indigent sick. I take it that, broadly speaking, there are three ways perhaps of taking care of the indigent sick in the United States, three methods; first, by public administration; second, by the so-called private public service hospital; and third, which is rather a combination of the two, care of



the indigent sick by the private hospital at the expense of public funds. In discussing the subsidy system, I am sorry that Mr. Clark used chiefly the Pennsylvania illustration. In Pennsylvania my understanding is that the subsidy system has been on the lump sum basis, and Mr. Clark refers to political scandals. It is perfectly true they have had political scandals with the subsidy system in Pennsylvania, and the tendency throughout the country has been to criticize public administration for it. A few years ago I made an investigation for the mayor of Cleveland, and I found that not only was public administration to blame but also the hospital politician. Mr. Clark says that the states are awakening to the fact that they owe something to private hospitals. I think they have been awake a long time. They realized many years ago that the public administration was not able to assume full responsibility for the care of the indigent sick, so they provided in the laws that hospitals doing a certain amount of free work should be exempt from taxation, and many of the hospitals in the States at this time are exempt from taxation; and right in this connection I want to say that in one or two states there have been recent decisions of the supreme court relative to the amount of charity work that a private hospital must do to be exempt from taxation; and in some information we gathered a short time ago, I make this assertion, that there are many hospitals in the United States, which if carefully investigated, would be deprived of that right. Only for the fact that the state auditors and county auditors are not doing their duty, many of those hospitals would today be under tax. I think the States are awakening, but, as you know, state governments follow public opinion, and I know two or three states in which the state governments are waiting for the hospitals to speak to them upon this subject; in other words, they are waiting for the organized hospital public opinion, and I know one state in particular which is anxious to have the hospitals of that state tell them what kind of a subsidy system is needed for that state. Mr. Clark says that mere aid is not sufficient, that there should be complete aid. Well, how are we going to determine on what basis the hospitals should be compensated by public administration? We will admit abuse wherever the lump sum appropriation system has been in effect, wherever the average daily per capita cost system has been in effect; wherever the state itself has had control over admission, has had the right of inspection of the



hospitals, has had the right to go over the books, the system has been much more effective. I think New York City is a very good example of this kind of a system, namely, the per diem basis. Mr. Clark suggests that this ought to be made a subject of study. I think there is an excellent opportunity here. The hospitals of the state governments, are many of them anxious to know what to do. They realize that they cannot care for all of the indigent sick; they are taking care of the insane, the feeble-minded, chronic cases, the tuberculous, and often the contagious, and when I say state government, I am speaking of a political subdivision, the state, the county, or the city. Why should not the American Hospital Association make a study of this question, a study of the lump sum appropriation scheme, a study of the per diem basis scheme? I suggest, as a temporary policy, that the subsidy system has been worth while. I know of a number of instances where it has been used as a temporary procedure. The political unit was building a hospital; they expected to take care of all the indigent sick in that community; they expected to take two or three years to build it; in the meantime they said, "We will enter into a subsidy arrangement with the private hospital as a temporary policy." That has worked, and at the present time in Cleveland the county is being asked to provide county aid for the county hospitals until the city completes its four million dollar hospital. Wherever the public subdivision has had control of admissions, the right to decide whether it would pay for this patient or not, the right of inspection, the right to go over the books, the right to enter into a contract with the individual hospital on the basis of fact and justice and common sense, there the subsidy system has worked; but how many of the hospitals of the country are familiar with that? A few of them. I really think that if the American Hospital Association wants to render a real public service they will, as Mr. Clark suggests, give a great deal of consideration to this subject during the next year. Mr. Clark speaks of the rights of the giver. I realize that there are experts who will say that the subsidy system should not be considered anywhere at any time. Those same experts would not even admit that the state had any rights whatever with respect to the private hospital. In conclusion, I suggest that if the subsidy system is entered into anywhere, the state has perhaps every one of those rights mentioned in this paper that the private giver has when he gives to

the hospital; it is a joint obligation, there are rights and duties on both sides and it can be made an effective instrument for the public welfare.

THE CHAIR: The third phase, "Money Obtained Through Whirlwind Campaigns," was to have been discussed by Dr. Pevoto. Is he present? If not, we would like to have anyone who has something to contribute to this discussion of this paper, do so.

MR. GREEN, Secretary of the United Hospital Fund, of New York: Some years ago, when the state of New York was engaged in a revision of the charter of the City of New York, the matter of public subsidies was very carefully considered, and after this careful consideration, the policy of granting subsidies to private institutions that were taking care of people who were proper subjects for the community, was adopted and written into the constitution. It has been working with thorough satisfaction, I think it can be said, on the part of the public officials and also of the general public in New York City. We have 135 hospitals in New York City. About twenty of them are municipal hospitals, the Bellevue and allied hospitals, the hospitals of the Department of Health, and of the Department of Public Welfare, which used to be called the Department of Charities. Now these twenty large hospitals of the city care for only about one-third of the sick patients. The hospitals that are connected with the United Hospital Fund number now fifty-five, and they have more than 40 per cent of the bed capacity of the city. We have there 30,000 beds, which makes one bed for every 200 of the population. The United Hospital Fund has been for some time making a thorough study of the situation and assembling the facts which would justify stronger appeals to a larger constituency in support of the private hospitals there, and a year ago we felt that the time was ripe to present this claim in a systematic and vigorous way. The response of the public was that whereas we had been raising about \$200,000.00 through the United Hospital Fund, this united effort produced \$949,000.00, and the result was so satisfactory that practically all misgivings and doubts have been swept away, and we are about to enter now upon an effort to raise this year \$1,500,000.00. The deficit of those fifty-five hospitals for the care of their sick poor is about \$4,000,000.00 a year; that is, four million dollars is needed in addition to all their receipts from operating returns and from invested funds, and it is probable that the

United Hospital Fund will, in a short time, raise that entire amount. Now, after it has raised this sum, you naturally will say, "Well, how is it distributed?" It is distributed by securing very accurate and uniform information from all these hospitals which wish to share in the distribution. We require them to make an annual report on this uniform blank that is furnished, in which they must give us exact facts with regard to all their patients and the number of days of treatment that are given to the different classes of patients, and with regard to their dispensary work; also with regard to their receipts and expenses and the per capita cost of the ward patient. I know some of you will say that it is impossible to figure the per capita cost of a ward patient because they are worked right in with the private patients, but you would not have any business man receive such an answer as that from some head of a department if he asked him to segregate his expenses. For instance, Wanamaker will have a wall paper department in his store; he wants to know whether he is making or losing money on the wall paper department, and it is useless for the manager to say, "We are part of the great store, you cannot separate those things." He does get it separated, and when I went to buy some wall paper at Wanamaker's this fall, they told me they had wiped out their wall paper department and did not have any. It is possible to get these facts and we do get them. It simply means more care, more thorough and systematic accounting. Bring in your auditors. All the hospitals have their auditors, and they have shown them how to make up a better case to the public, and no money is better spent than in putting your house in order so that you can make your claim. Beware of these people who do reckless publicity. I noticed a headline, "Five Thousand Dollars for a Drink of Milk," that was put out by a bright newspaper man to help a campaign for a certain hospital in New York. I called up the superintendent and said, "What does that mean?" He said that this bright publicity man thought that they might use a great deal of milk there and it might cost five thousand dollars a day. I said, "Does it cost you anything like that for milk for a week?" He said, "That is perfectly ridiculous, I am ashamed of it"; and when I called his attention to it, he said, "Nobody would know whether you ought to pay five thousand dollars or ten thousand dollars for a drink of milk." A great many people would know, and the big givers would

know, and I believe it is a safe thing to make your facts and statistics absolutely irrefutable, and you can go and look any man in the face and get money from him because he will see that you have got the facts. I published a sheet a foot square of statistics with about ten thousand different items. You will say, "Who cares anything about that?" I went to a man on Wall Street and his private secretary told me, "You could not get him to raise his contribution from a thousand dollars under any possibility." I said, "May I just see him?" He said, "He is very busy, he will come out of a directors' meeting as hungry as a bear, and you won't get it." However, I waited and he came out of his private office and his secretary said, "Here is the man from the United Hospital Fund, he wants his contribution." "Well, give it to him." The secretary said, "He wants five thousand dollars." He looked at me as if he thought I was crazy. I flashed out this statistical sheet and said, "We do not want simply a large contribution, we want you to know the basic facts and want the public to follow your example. You are at the head of this procession." He took the sheet in his hand and took the hospital of which he was treasurer and took the per capita cost, \$3.25, and right under it was another hospital, \$1.79. He said, "Do you mean to say that we spend \$3.25 per capita while this other hospital spends only \$1.79?" I said, "That seems to be the fact." He said, "Just step into my office." I did so, and in that interview he learned more than anybody on his board of directors could have told him. The result was that I walked out with a check for five thousand dollars, and last year he gave twenty-five thousand dollars.

THE CHAIR: We will take up the next paper on the program, "Industrial Clinics in General Hospitals." That is a new idea. In many general hospitals I have no doubt this very morning patients are walking into the outdoor department with certain symptoms, the doctors recognize the symptoms and name the disease, but they have not the slightest idea that some industry in that city is causing it and that it is possible for those who are expert to recognize that fact and improve the methods of that industry so they will no longer be hazardous, and we are going to have something on that subject, and the one who has been asked to write about it is particularly competent; he is the secretary of the Industrial Hygiene Committee of the Harvard Medical School and of the Institute of Technology, both in Boston, Mass. It gives me pleasure to introduce Dr. Wade Wright.

DR. WRIGHT: The time has already passed when hospitals received patients for diagnosis and treatment as a chemist receives an unknown ore for analysis, with as little consideration for the source of the material and with less regard for the niceties of a report upon work done. A patient enters, occasions an academic pursuit of a diagnosis, receives more or less treatment, and leaves improved or unimproved, or worse, perhaps satisfied, but practically unaware of the real causes of his disability and ignorant of ways for safeguarding his health.

We have come slowly to realize that many of the factors in the production of disability through illness lie in the ways of an individual's life, in his work, and in his home and recreation. It is curious that much earlier physicians considered these same factors important in the treatment of disease.

There has been an uphill struggle in medicine for the simplification of diagnoses and the use of standard nomenclatures, both of which are undoubtedly desirable. Perhaps due in part to this effort, however, there is a prevalent tendency, more notable among internists than surgeons, loosely to fit their patients with diagnoses carried in stock. If the diagnosis happens ill to become the case, the physician comforts himself with the self-assurance that it is as good as any other at hand and that similar diagnoses have well served rather similar cases. It is difficult to exaggerate the importance of this tendency. It may be evidenced to the doubting by an examination of the medical records of the average hospital practitioner, which disclose in many instances a fancy for modish diagnoses, ready made, not custom built. Even in the presence of specific infectious disease, may the error be committed. In many cases of phthisis neither the origin of the disease nor the necessary treatment is adequately indicated by the words "tuberculosis, pulmonary." It is nomenclature simplified beyond the bounds of greatest helpfulness.

To be truly useful, this diagnosis of pulmonary tuberculosis should be supplemented by social diagnoses concerning influences in the patient's life which were perhaps almost as potent as that of an infection in producing his illness. They certainly are essential to the intelligent direction of treatment. The patient suffers from pulmonary tuberculosis plus "malnutrition," or plus "faulty working conditions," or plus "bad housing." The dispensary diagnosis of "pregnancy" in the case of an un-



married girl may be technically accurate, but it is obviously incomplete without the indication of some additional diagnosis, such as "feeble-mindedness"; nor can treatment begin and end with the recommendation of a lying-in hospital.

The dispensary diagnosis of "lead poisoning" in an industrial worker may be made on unquestioned clinical evidence; but it is insufficient as a statement of the cause of disability, and drug therapy is nearly useless if not supplemented by educational therapy based upon the diagnosis of lead poisoning plus some such supplemental diagnosis as "ignorance of industrial hazards." As much as a standard nomenclature of medical diagnoses do we need a standard nomenclature of social diagnoses.

A great part of our people are working people engaged in various industrial and mercantile pursuits. Not only are these workers subject to certain conditions during the hours of their employment; but even in the homes in which they live, the food they eat, the clothes they wear, their play, their contentment, their worries, their opportunities for social intercourse and for intellectual advancement of themselves and their families are usually, in great measure, determined by their work and the wages which they receive. It is in recognition of the importance of work in the life of the individual, in recognition of its importance as a factor in the production of ill health, that there has been developed the branch of medicine called industrial hygiene. Industrial hygiene is not concerned alone with industrial poisonings and the intricate problems of ventilation, of illumination, of dust, and of excessive fatigue; but is concerned broadly with the health of working men, women, and children, with the development of ways through which medical science and medical art may serve better than they now do the multitude who labor in industry.

General hospitals are usually located in large communities and the patients they receive are, in large part, working people. It is wholly practicable to maintain, in connection with such a general hospital, a clinic or department to which may be referred in consultation cases presenting conditions possibly related to industrial activity or environment. Such a clinic should be served by at least one physician technically qualified to consider problems of industrial disease and industrial hygiene. Unfortunately, industrial hygiene is relatively a new field and there are few such qualified physicians at the present



time. Certain functions of such a clinic may be entrusted to an investigator who is not a physician but is suitably trained. It should be the function of this clinic, with detailed knowledge of the patient's industrial history, to reckon fairly the probable relation of the individual's work to his disability. It should be prepared to undertake necessary investigative work; and, if possible, should be affiliated with laboratories equipped for the performance of such laboratory research as may be suggested. The staff of the clinic could scarcely hope to be of real service without being thoroughly acquainted with the local industrial life and the details of operation of representative processes.

In a general hospital such a clinic can best be established in connection with the hospital dispensary, but in this department the clinic, if it is to be operated to advantage, should have the privilege of selecting its own clinical material from among the new admissions. The demonstrated inability of most clinicians to recognize either specific industrial maladies or the common effects of industrial health hazards would obviously preclude the possibility of their referring to an industrial clinic the cases meriting its attention.

In the selection of material for the industrial clinic it is by no means wise to be guided by the complaints of patients, but rather should the selection be based upon consideration of the occupation of the patient, and even of his previous occupation. Many cases of important and severe occupational disease are thus detected in individuals who present themselves in the hospital for the relief of trivial and coincidental ailments or who come complaining of some trouble which is in reality a symptom of significance only to one acquainted with industrial disease and the hazards of specific trade processes. Severe lead poisoning has been found in men who presented themselves for the treatment of eczema, of a laceration, of chest pain.

The importance of the study of previous occupation is worthy of emphasis. It is notably difficult to observe in many industrial establishments the ill effects of hazardous operations, inasmuch as affected individuals or those especially susceptible not infrequently go from their hazardous jobs into other work. Such persons, however, are frequently encountered in the dispensary clinics of our large general hospitals.

Not only in the accurate diagnosis and the consequent

accurate prognosis and efficient treatment of industrial workers may the industrial clinic serve, but also in the incidental observation of working and living conditions which affect working people. Statistical studies of illness of industrial workers and of absenteeism due to ill health are of the greatest moment because of their economic importance and their relation to the public health.

There has probably never been so great a general interest in the promotion of the public health as there is now, yet it seems that too often the public health is vaguely visualized as something other than what it really is, the composite of the health of individuals. We diligently search for signs of incipient public ill health and fail to seek incipient illness in the individual.

Medical students may be taught for months regarding the clinical manifestations of typhoid fever and pneumonia and gastric ulcers. They are not taught one hour the significance of such signs as headaches, dizziness, back aches, indefinite muscle pain and mild digestive disorders, except as they may be discussed in connection with critical illness. They come to accept as desirable grist for their mill only the seriously ill, the badly deformed, the markedly defective. They labor long in wards and laboratories upon methods for the determination of the renal function of nephritics, gauges of the severity of disease or of the efficacy of treatment in a disease rarely detected in its earliest stages.

It is true that hospitals receive, for the most part, persons known or suspected to be truly sick; but there is undoubtedly in the dispensary clinics of general hospitals an excellent opportunity to study incipient disease, which is, after all, of greater importance than advanced disease. Such study would make possible a contribution to the public welfare which may reasonably be expected of great medical centers, such as general hospitals. Certainly those who minister to the sick hold a trust for the well.

In industrial and mercantile establishments there are assembled an enormous number of individuals, a number greater than those in our schools. In the detection of incipient disease, and of other physical and mental abnormalities among workers, in the securing of needed medical attention, much may be accomplished for the public health. It is a task which industrial clinics in general hospitals might well share.

Through the accumulation of classified data regarding the nature of the complaints, symptoms, and diagnoses

among various types of industrial workers, we are coming to learn of prevalent disorders and of the relation of these disorders to working conditions. We have learned of the relation of tuberculosis to various occupations. We have learned of the prevalence of respiratory disturbances among various types of textile operatives, of fatigue neuroses in certain trades, of the frequency of gastro-intestinal disorders in the candy and sugar industry. Though specific industrial diseases are not uncommon, they are, compared to other ailments, relatively few. On the other hand, the deleterious effects of many sorts of work are numerous and important.

It is hardly possible in a general hospital to establish the relation of industrial health hazards to ill health except in a special clinic or hospital department; but such a center must inevitably serve to stimulate in the staff at large a new interest in industrial disease and the effects of industrial health hazards, and to spread new knowledge. Beyond the hospital the findings of such clinics may go to industry itself, to the end that unfavorable conditions of work may be remedied.

In recent years there has been a rapid development of medical service in industrial and mercantile establishments. The impetus of this movement was unquestionably given by the general adoption of Workmen's Compensation laws. Industry, however, is slowly becoming aware of the value of health among industrial workers, and employers and employees are only beginning to realize that health is not to be made secure by the surgical dressing of occasional industrial injuries.

The growth of industrial medical departments and the institution of the physical examination of industrial operatives have indicated to general hospitals in industrial communities a new field for usefulness. It should be possible for such hospitals to cooperate with industry to the end that the resources of the hospitals, in personnel and equipment, be more fully at the command of the communities they stand to serve, and that without the endangering of high professional and institutional standards or the serious altering of properly established hospital procedure. It should be possible for the general hospitals in a community to arrange for the prompt reception of all industrial casualties and for their proper care upon a basis of full compensation for the cost of treatment. Whereas the costs of hospital service have greatly increased in recent years, there has been but slight in-

crease in the amounts authorized by most state commissions administering Workmen's Compensation acts, with the inevitable result that persons incurring industrial accidents, instead of receiving the fair or even preferential treatment to which they are entitled, are in numerous instances in many communities receiving exceedingly inferior care. There is ample justification in many cities for the establishment of distinct hospitals or hospital divisions for the hospitalization of industrial accidents, where under the strictest administrative control there may be developed resources for the prompt and efficient transport and reception of industrial accidents, and for the care in comfort of such cases. There should be provided resources for the treatment of such industrial cases by the best methods available, methods not always in common use in general hospitals, including those for the care of industrial eye injuries, the treatment of serious burns and fractures, as well as facilities for the restoration to function of impaired members. The cost of such hospital care should be borne in full by industrial commissions or designated insurance carriers, or shared by the employers of injured workers. It obviously should not be paid in whole or in part out of private hospital funds, as is now so frequently the case.

There is to be noted in industrial establishment medical service a rapidly growing need for skilled consultants, for efficient laboratory service, for medical care for physical and mental defectives, and bed care for the seriously ill. All of these needs can be met by the general hospital in an industrial community. They cannot be met, in most instances, without some modification of existing regulations or without some sound policy regarding the payment for services rendered.

Almost all general hospitals are in a sense, in part industrial clinics. Few realize it and fewer still have endeavored to develop any organization through which their contact with industry may be made.

It has been difficult for medicine to understand industry and for industry to understand medicine; but there is possible a mutual understanding, for they have a common purpose in the serving of the common good.

THE CHAIR: I meant to have said, in introducing Dr. Wright, that he was also in charge of the Industrial Clinic of the Massachusetts General Hospital.

Meeting adjourned.

# AMERICAN HOSPITAL ASSOCIATION

## SECTION ON NURSING

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, October 6, 1920, 8:30 P. M.

MISS E. M. LAWLER in the Chair.

THE CHAIR: It is my privilege to preside at this meeting of the Nursing Section of the American Hospital Association, and we have tried to arrange for papers that we felt to be of mutual interest to everyone. At no time could we have so easily chosen a subject that would be of such vital importance to both hospital and training school administrators as we can today, that of course being the question of the shortage of nurses. That there is a shortage we all agree, in hospital positions, out in private practice, and in public health work. Of course, there are demands for nurses that cannot be met. More serious than this is the report that comes to us from all over the country of the shortage in applicants for our training schools. There is one hopeful and cheerful thing about the situation. For many years, perhaps, nurses themselves have felt that there were a great many things wrong in our schools that it has not been possible to remedy, because so long as we could get enough pupils to carry on the work, it was not of equal importance to everyone; but now we have come to the place where the pupils cannot be had and the hospitals are suffering, and we will have to get together and get to the bottom and decide what the cause is and what can be done to remedy it. I think we are rather unanimous in the cause of the shortage; first, that there is a shortage in every profession, and not only do we not have enough nurses, but it is a difficult thing to find enough workers in any field. Then, too, this is a commercial age and the financial return in the different branches of nursing has not increased as it has in other professions, and the young woman who is looking for a thing that will be financially good will not select the training school. Then there is the question of difficulty in the school themselves; so much has been said of long hours, hard work, unattractive living conditions, and poor teaching, that the young woman of today is looking into the school before she decides to enter.

In arranging the papers tonight, we have tried to have one that will deal with a remedy, perhaps, for each one of these conditions existing in our schools which are making it difficult. Every superintendent of a training school knows how difficult it is very often to provide for the proper teaching, that is to arrange for the lectures and the class instruction; so Miss Gunn will tell us about something they have been able to do in Toronto. Miss Gunn tells me that the title of her paper is not what she is going to talk about; she is going to tell of a centralized group.

MISS GUNN: In presenting the subject of centralization of teaching in schools for nurses the discussion will be limited to an experiment being carried on at present in the city of Toronto. The same system may be in operation elsewhere, but it has not been possible to secure any definite information of similar experiments in other localities.

To those who are not familiar with the city of Toronto, a brief outline of the hospital facilities may be of interest. There are, in all, eleven public hospitals besides the smaller private hospitals. Several of these public hospitals are affiliated with the University of Toronto and are therefore teaching institutions for the Medical School, while others have no connection with the University. All, however, conduct training schools for nurses ranging in size from 250 to 12 enrolled students.

Before the recent war these schools carried on their work quite independently, with no interrelationship. Then with the war came the shortage of medical men, not only in private practice but particularly on the University staff and the staffs of the different hospitals. All were overworked and new conditions in our training schools were consequently brought about.

As time went on we found these conditions. Medical men already teaching in the University were teaching the same subject in two or three schools for nurses. In one case, which was typical, a lecture course covering eight hours was being given by one surgeon in three schools, which meant twenty-four hours instruction instead of eight. Conservation of the instructor's time was, therefore, one of the outstanding reasons for the organization of a central teaching course. Another difficulty was the inability of the smaller schools to teach the subjects as outlined by the curriculum of the Graduate Nurses' Association of Ontario. These schools were expected to meet this standard to make their graduates eligible for mem-



bership in professional organizations. Under the conditions existing at that time it was not possible for them to do so. A busy physician might make the time to teach a class of forty to seventy students, but would not feel that he could spare the time to teach a group of four. Yet these four students had to be taught.

In 1917 it was, therefore, decided to make an effort to centralize part of the teaching, particularly the lecture courses given by physicians. As none of these schools had a class room sufficiently large to accommodate the students, the University of Toronto was approached and a class room in the Medical Building was provided. The University, while extending this courtesy to the training schools of the city each year, has no connection with the lecture course, but simply provides the necessary class room.

### Committee of Superintendents Centralize Certain Teaching

A committee was organized which consisted of the superintendents of nurses of the different schools. This committee has, since its organization, been responsible for the arrangement of the entire course. In regard to instructors the committee decided to leave the appointment of instructors in the different lecture courses to the medical faculty of the University. Each year the nurses' lecture courses are assigned in this way to some member of the teaching staff. While the schools have no direct affiliation with the University, the teaching in these subjects is planned for unofficially by the medical faculty.

Of the eleven schools, nine entered their students in the centralized course. It has not been possible to arrange as yet for the teaching of all theory in this way and the individual schools continue to teach certain subjects. The following subjects are taught in the centralized course: in the first year; general medicine, eighteen hours; bacteriology, twelve hours; hygiene and sanitation, twelve hours; in the second year; surgery, twelve hours; gynecology, eight hours; orthopedic surgery, six hours; infectious diseases, ten hours; mental diseases, four hours; in the third year; obstetrics, eight hours; pediatrics, twelve hours; medicine, six hours; surgery, four hours; ear, nose, and throat, three hours; eye, three hours.

In addition to the above, the eleven schools entered their junior students for a course in chemistry arranged

and given by the Central Technical School. This course covers a period of three months, with one hour class and one hour laboratory work weekly. This has been of great assistance to all the schools, as none were properly equipped to teach chemistry. The centralization gave the students the advantage of expert instruction and the use of a laboratory which could not possibly have been duplicated in any of the eleven training schools.

Another course into which all the schools are centralized is offered by the University of Toronto. This course in public health nursing is arranged by the University especially for the student nurses, to give them some idea of the scope of public health and social service work and to familiarize them with the many fields of work. One hour a week during the senior year is given to this course. In connection with it the Department of Health of the city receives the student nurses for a period of two months field work. This practical work is of great value to the student, as it gives her an opportunity of associating the theory taught with the conditions that exist and the means adopted to remedy them. The time is short, but long enough to impress the student with the need for public health activities.

### Examinations Made Uniform

The examination in chemistry is given by the staff of the Central Technical School, and the University of Toronto gives the final examination in public health nursing. It has not been possible yet to arrange a system of credits in the University for this work, as the course taken is a specially arranged course and not one regularly arranged for full time students. In all other subjects the examination is set by the instructor and the papers are read by an examining committee appointed by the training schools. The examinations are written and are held in the different schools at the same hour.

### Advantages of Centralization Outweigh Disadvantages

Every system of education has its advantages and disadvantages. One of the outstanding disadvantages of this system of centralization is the fact that the students are absent from the ward longer than when the teaching was done in the individual school. The student has to have extra time to enable her to go to and from the University class room. While this is a disadvantage from

the standpoint of the direct administration of the nursing of the hospital, it is rather an advantage to the student. She has a walk in the fresh air and a change of atmosphere which cannot fail to be of direct benefit to her.

Another disadvantage is the fact that the students are taught in a much larger group and do not receive the same individual help and instruction which is possible in smaller classes. To counteract this defect, many of the schools arrange for short conferences on the lecture given, or hold bedside clinics in the wards in order to link up the subject taught with the actual daily care of the patient.

The advantages naturally fall into three classifications: those which are general to all schools; those especially relating to the larger schools; and those relating to the smaller schools.

Of the general advantages, the most striking is the better teaching in these subjects. The instructors give careful preparation to the subject and are experienced in teaching, which unfortunately the physicians who are often called upon to assist the teaching of student nurses are not. The majority of nurses of today can easily recall lectures in their course that had received no thought and consequently no preparation on the part of the physician. Another advantage is the promotion of uniformity of teaching and standardization of the curriculum of the city schools. A spirit of competition is created by the system of uniform examinations. Some students who do not feel a great deal of anxiety concerning their individual standing, curiously enough, have a certain interest and pride in the standing of their class and training school. It is also beneficial to the student to meet students from other schools and to obtain thereby a broader outlook.

From the standpoint of the hospital, the centralized system of education has brought about a close cooperation between the schools for nurses, linking them up with a common interest and undertaking.

From the standpoint of the physicians and surgeons who for so many years have given so freely of their time in nurse instruction, the centralized teaching is a great saving of time. So frequently the same physician or surgeon gives the same course of lectures to different groups of nurses, and is thus forced to cover the same ground three times or even four times during a term. In these days when everyone's day is more than full, the economic value of centralized education cannot be overlooked.

The advantages specially applying to the large schools are not as vital as to the smaller schools. The larger school is always in a position to arrange proper education in all subjects for its students, but this system gives the larger school an opportunity to assist the smaller school to meet the same standard, which would be impossible for it to meet otherwise. The chief advantage, therefore, is the knowledge that the large school is not limiting its activities to its own field, but helping to meet the need of the community where all hospitals and students are necessary for the care of the sick.

The advantages to the small school are very apparent. It is provided with a means of teaching its student nurses according to the approved curriculum. The students know they are receiving the same instruction as the students in the large schools and that they must reach the same standard, for the examinations are uniform.

### Single Director of Nurse Education Would Facilitate Teaching

The future of this plan of teaching has still to be decided. The committee feels that the appointment of a director of nurse education for the hospitals of the city is most essential. This innovation will probably be the next development. If such an appointment is made, the expense will be shared by the schools in proportion to the number of students enrolled. A director is really essential to link up the teaching in the lecture course with the supplementary teaching in the individual school. At present this connection is left to the school and no uniformity results. Another reason for this appointment is to save the time of the hospital executives, as nine or eleven schools, as the case may be, send a member of the executive staff with the students to each lecture. One such person is sufficient if she has some connection with each school to enable her to plan the necessary supplementary work.

One of the changes that the committee is hoping to effect is to pay the instructors of this course. At present the physicians and surgeons give their valuable time voluntarily and would continue to do so very willingly. In fact, the hospitals could never adequately pay these instructors for their time; but if some basis of payment were adopted, the schools would be much more independent and self-respecting, as they would at least have made an effort to meet their obligations.

## University Education for Nurses Final Goal

The last dream of the committee will perhaps remain only a dream. It is that some time in the future the education of the student nurse in our city schools will be undertaken by the University of Toronto in close cooperation with the board of managers of the hospitals. The hospital can be the working laboratory for the student nurse as it now is the working laboratory of the student in medicine. The medical school of any university is very closely affiliated with the hospitals. The carrying on of this branch of education in any university is directly dependent on the cooperation and good-will of the hospitals in its vicinity.

Why should this cooperation and good-will be as one-sided as it is at present? The hospitals have fields of practice that the school of medicine needs for its existence and development. The universities have fields of medical knowledge very much needed by the hospitals for their student nurses. Is it, then, not logical to expect this affiliation between hospital and medical school to extend to both groups of students? The rapid development in public health work throughout the United States and Canada shows clearly that the community demands and expects to receive as much help and advice in disease prevention from the graduate nurse as from the graduate in medicine.

This principle applies not only to the public health field. The scientific treatment of disease in our hospitals depends largely on the intelligent cooperation of the nursing staff. The day when the nurse's responsibilities were limited to the actual bedside nursing care of the patients is long since past. Is it, then, logical for the medical faculties of universities, the federal, state, provincial, and municipal governments and the public to expect expert nursing service in all branches of medicine, curative and preventive, when the best facilities for the nurse's education are withheld? All other branches of teaching are finding a place in the educational efforts of both countries. Why not the profession of nursing?

**THE CHAIR:** It seems to us that the scheme they have worked out in Toronto would apply equally well in large or small cities and would solve a great many of the difficulties that the school are laboring under now.

Miss Claribel A. Wheeler, director of the training school at Mt. Sinai Hospital, Cleveland, is going to tell

us about the use of the helpers who have been able to relieve the nurses of some responsibilities. I introduce Miss Wheeler.

MISS WHEELER: In bringing to your attention the subject of hospital helpers, I am presenting by no means a new subject, as women rendering the service now designated by this title have been employed in several of our hospitals for many years. This type of worker has, however, not been definitely recognized, nor has her economic value been fully appreciated. Recently we have heard considerable about the ward attendant, the ward assistant, or the hospital helper. The last name is perhaps the most appropriate, as the duties of this group are not confined to hospital wards, but they are employed in all parts of the hospital.

I was requested to present this subject, not as an authority on hospital helpers—I doubt if there be such at the present time—but because of the fact that in the hospital with which I am connected we have employed such assistants for several years with more or less success. I simply wish to give you some of the results of our experience with them, and trust that this short paper may serve to bring out helpful discussion on the subject.

### Helpers Supply Several Acute Hospital Needs

The growing need for the hospital helpers is obvious; the increased number of hospital beds paralleled by the increased demand for nursing service, and the recent dearth in the number of applicants entering schools of nursing, have made it necessary to look to some other class of worker to assist in giving the sick adequate service. It is, perhaps, a good thing that this situation has arisen, in order to bring to the attention of hospital authorities the fact that women who are not highly skilled can do certain things, which never should have been delegated to student nurses, who are in hospitals to study the science of nursing and not to perform tasks of no value to their training. With the shortage of students in many schools, it has become necessary to employ graduate nurses, and the folly of paying these women to dust rooms, arrange flowers, and carry trays is at once recognized.

Various measures have been sought to remedy this situation, one of the most notable being the plan for training and registering attendants, a class of women to care for the sick. Laws governing such a practice have already



been passed in New York State. Whether a second class nurse is needed is a debatable question. Many leaders in the nursing profession, as well as physicians, hospital superintendents, and lay people, believe that the untrained attendant is a step backward, especially as medical science is rapidly advancing and great strides are being taken in the protection of the health of our people. To keep pace with scientific medicine and properly to carry out new health measures which are constantly being enacted by law, we need better educated, better trained nurses than have been needed before in the history of the world. It seems hardly wise or expedient to delegate bedside nursing to those who are not properly fitted by education and training to carry out the technical procedures now considered essential. Other ways, such as the development of a more extensively paid visiting nurse service, and the establishment of an hourly nursing service by private duty nurses, seem more worthy of consideration. Certainly in hospitals the attendant is not the person whom we are seeking; the helper does seem to meet the situation fairly well.

### Functions of Hospital Helpers

The distinction between hospital helpers and ward maids is not clear in the minds of some people. When we look at the type of ward maids found in the majority of our hospitals today the difference is easily detected. Surely this woman who scrubs floors and cleans hoppers cannot come into any very intimate contact with sick people; she is usually Italian, Polish or colored, and she often speaks very little English. In most of our hospitals the ward maid is under the jurisdiction of the housekeeper instead of the nursing department. The hospital helper, on the other hand, must necessarily be a woman of better type; she must speak English and present a good personal appearance. She is an adjunct to the nursing service which is a distinct advantage, as her tasks are much more intimately connected with nursing than are those of the ward maid.

The work which can be delegated to hospital helpers is not to be confused in any way with nursing; the tasks performed by them, it is true, have heretofore been done by nurses, but they were not nursing procedures. They are the things which have warped and narrowed the training of the student nurse by their ceaseless repetition, and have prevented her from receiving more important prac-

tices, as well as having been instrumental in prolonging her hours of duty. It is true that student nurses should learn the science of cleaning paint, marble and brass; that they should be taught how to serve trays, arrange and care for flowers and make beds; it is necessary, however, that they repeat these things throughout three years.

Hospital helpers may be taught in the wards to dust beds, stands, and window sills, to clean utility rooms, to make empty beds, to disinfect beds, to put in order private rooms after patients have gone home, to arrange flowers, to fold and put away linen, to assist the nurses in serving and carrying trays, to run errands for the ward. They are useful in the nursery to assist in many ways in the care of the babies. In the operating room they can be taught to clean instruments, to wash and mend gloves, to sew on buttons and tapes, to make and put up supplies for sterilization, and a hundred such details too numerous to mention. All surgical dressings for the hospital can be made by them, for it is a useless waste of time to require students to pull washed gauze and to make up dressings. The admitting room has a place for the helper, also, as here she can be taught to assist in the admission of new patients, giving baths, listing and putting away clothing, etc. She may become a useful assistant in the out-patient department, where it is often difficult to secure an adequate corps of assistants, and where nurses often spend hours on useless detail. In fact, there seems no place in the hospital where nurses are employed that these helpers cannot be used to advantage.

Conceded that the helper is an essential individual in the present day hospital, the question is, Where are we going to find her? How are we going to retain her when once captured? From personal experience the helper may be found in three rather distinct classes. The most common and the most dependable are young women from eighteen to thirty years of age, who have a real desire to be associated with sick people; but who do not possess the necessary educational qualifications for entering training. If this group can be sufficiently impressed with the fact that they are rendering a much needed service and are really instruments in caring for the sick, they may be satisfied to remain for a considerable period of time in the hospital. The second class is composed of high school girls desirous of earning something during the summer vacation. Many in this way become interested in nursing and decide to take the nursing course. We

have had several who have in this way become interested in our school. The last group are women who perhaps do not have to work for a living; but have taken the Red Cross courses in hygiene and home nursing, and are willing to come into the hospital in time of an emergency or epidemic or even for the summer to relieve for vacations. Several such women have served in Cleveland hospitals during the past summer.

In most hospitals, as in our own, I believe, the helpers are taught by the head nurses. It would seem feasible and advantageous to instruct them in the principles of hygiene, the art of cleaning and folding linen, the care of flowers, etc., and to demonstrate to them the procedures required of them. These classes could be given by the instructor in nursing methods. Without doubt this instruction would give them an added interest in their work and would make them feel that it was more worth while. Another advantage would be their uniform training.

A distinct uniform for the helpers is, of course, necessary, but it is a question whether they should be supplied by the hospital or provided by the helper. Most hospitals supply uniforms to maids and porters and could furnish them equally well to the helpers. A plain wash dress with white collar and apron seems most desirable. Rubber heels on shoes should be required.

The housing problem seems to be a difficult one for this group, as they cannot be housed in the nurses' residence and they do not fit in well in the servants' quarters. In most places they live outside the hospital. One or two meals are provided and the uniforms are laundered by the hospital. There seems to arise a question as to where they shall have their meals served. In some places they eat in the nurses' dining room, in others in the employees' dining room. In our own hospital they are served in the employees' dining room, but not at the same time as the other employees.

Salaries for this class of worker seem to vary; but from what I can learn from hospitals employing them, they are paid anywhere from \$35 to \$60 per month for eight hour duty. It would seem unreasonable to ask any woman to do such work for less than \$55 or \$60 per month, and institutions paying less than this will have trouble in securing them.

Without question, there are many disadvantages in employing hospital helpers. In the first place, they are hard

to find, which is, of course, equally true of finding orderlies, waitresses, and ward maids. Advertising in the daily papers, applying to agencies and securing them through the hospital social service department seem the best methods. As has been mentioned before, housing them presents a serious problem, as does the serving of their meals. It is also asserted that some of them go out and pose as nurses, charging nurses' fees. This is nothing new, however; hundreds of untrained women are doing it constantly, and will continue to do it until proper laws have been made for the protection of the sick public. It must be remembered that the helper does no actual nursing and should be made to understand clearly her relation to the nursing department.

It would seem that the advantages of employing helpers far outweighs the disadvantages. In hospitals where graduate nurses are employed it is certainly cheaper to employ helpers to perform household tasks than to require nurses to do them. In others, where the burden of the nursing service falls upon the student body, the helper is a factor in relieving the pupils of much unnecessary routine, and in shortening their hours of duty. Young women eligible to schools of nursing may in this way become interested in later taking the regular nursing course.

The helper seems to have become an essential part of the hospital personnel; she is a decided asset to the nursing department, as she relieves the skilled worker of unnecessary details; she is a valuable factor from an economic standpoint. Consequently, greater consideration is shown her, her life will be made pleasanter, and the service she renders greater.

**THE CHAIR:** As these several papers we have tonight deal really with the same topic, we will postpone the discussion until after the completion of the papers.

It is said that one of the criticisms we receive concerning the training schools is that the students are not properly prepared for the work they wish to do after they finish. Miss Annie Goodrich, director of nurses, Henry Street Settlement, New York, will speak on "The Preparation of the Student Nurse for Public Health Nursing."

A recent call to deliver an address on nursing education was accepted with some mental perturbation, through the indication that an attitude still prevailed toward the subject, on the part of those concerned,

that, with the developments in the fields of education, science, and health, should, it would seem, have disappeared. The urging of emphasis on the relation of the nurse to the doctor; a gentle caution of restraint in discussing the required body of theory; the reappearance of the "overtrained nurse," a characterization once popular but that has gradually faded out; all conspired to arouse this apprehension. Subsequent events, however, did not justify the preliminary anxiety. A group of some twenty graduates of the Teachers' College, Columbia University directors, and instructors of schools of nursing and nursing organizations, gathered together at dinner. An attentive and seemingly interested audience was reassuring, while the revelation of a notably progressive and extensive program of nursing education, with good promise of its early launching, was revivifying indeed. It proved a day of happy and inspiring episodes. Nevertheless, that day has resolved itself into the insistent question—"Does, after all, any appreciable part of the community yet grasp the significance of the increasing dissatisfaction of young women with our training schools for nurses?"—and a haunting memory of a row of newborn babies in the grim ward of the venereal department of the municipal hospital of that city.

Contemplative knowledge, Dr. Dewey informs us, has been superseded, "through the demonstrations of science that knowledge is power to transform the world," by practical knowledge.

"Nowadays, if a man, say a physicist or chemist, wants to know something, the last thing he does is merely to contemplate. He does not look, in however earnest and prolonged a way, upon the object, expecting that thereby he will detect its fixed and characteristic form. He does not expect any amount of such aloof scrutiny to reveal to him any secrets. He proceeds to do something, to bring some energy to bear upon the substance to see how it reacts; he places it under unusual conditions in order to induce some change."

We know today with an almost mathematical certainty the physical unfitness that can be found in any given unit of population. Various reliable authorities have reported figures. We are informed, for instance, that in a unit of population of 100,000 there would be approximately 2,000 constantly sick, 1,000 suffering with tuberculosis, one out of eleven would be potential mental cases, one to ten

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1. Dewey—*Reconstruction in Philosophy*, p. 112.

would be the ratio of venereal disease. The weekly health index from the Department of Commerce, Bureau of the Census, informs us of the variations in the infant mortality rates throughout the United States. New York's is lower than some smaller industrial towns, but still higher than London's report for 1920, seventy-five per 1,000 births.

We know today with a hardly less mathematical certainty the percentage of these conditions that can be remedied, a large one, and the percentage, even larger, that can be prevented.

Whatever the future may bring, every health program today, whether for war or for peace; whether Federal, state, county, or municipal; whether dealing with the remedial aspects of the situation through the various institutions and organizations for the care of the sick, or dealing with preventive measures through various organizations and institutions such as schools, factories, and homes, demands in ever increasing numbers the worker designated as the nurse. The most casual observer of statistics issued by the visiting nurse service of the Henry Street Settlement for the year 1920, must be impressed with the opportunity of the nurse to function remedially and educationally in the community. In one year, nurses were called to 42,902 persons, and had 336,722 contacts with those members of the community most likely to be victimized by the defects of our social system, for no investigation has yet revealed that a majority of those who are unable to take their place honorably and effectively in the community are individuals of good physical condition and surrounded from birth with a reasonably good environment. Quite the contrary.

When curative medicine was seeking for a tool with which to apply its remedies, or surgery to carry out its technical procedures, the trained hands of the nurse, motivated by medical minds, functioned perhaps adequately, but the wider demands of the field of preventive medicine call for a different type of worker.

Under the caption "An Epitome," a student in the department of nursing and health, Teachers' College, writing of the essentials for the practice of nursing, in cryptic phrases portrays the nurse required today. Of this portrait we have but one criticism to offer, the inclusion of great enthusiasm as a requirement is redundant! The absorption and assimilation of such a content of education



as is suggested would supply, we believe, an unceasing stream of that emotion.

A change has taken place in the past few years in the attitude of educators, of the medical profession, and the public at large, toward this public servant, a greater change perhaps than even those who are most closely concerned in the developments in the fields of nursing realize. But is it through their awakening appreciation of the need of a different preparation for the fields for which the nurse is destined, or through the necessity of attracting young women in larger numbers to those fields?

The hospital, the greatest sufferer in the shortage, since it has depended so entirely on the student nurses, finding them an easy method of obtaining service at the smallest price, through the many fields now open for women, through easier means of self-support, and, above all, through its own failure to give the students a satisfying content of education, is obliged to accept the fact that some readjustment is called for since the former things have passed away.

Human nature, however, has not changed, "Man is possessed," says Veblen, "of a taste for effective work, and a distaste for futile effort. He has a sense of the merit of serviceability or efficiency, and of the demerit of futility, waste, or incapacity. This aptitude or propensity may be called the instinct of workmanship."<sup>2</sup> The student mind, so illustrative of this instinct, has always been and still is indifferent to commercial ends except in so far as daily bread is imperative, or money is needed to procure mental satisfaction, and the student mind is increasingly with us. Thousands of young women, where formerly there were hundreds, are now going through the high school, thousands even are pressing for admission to our overcrowded colleges. Never in the history of the world were minds so eager for knowledge or so alive to the purposes to which it should be bent, and for that reason the call of the field of nursing should make the greater, not the less, appeal.

To quote again from Dr. Dewey: "In fact, the whole conception of knowledge as beholding and noting is fundamentally an idea connected with esthetic enjoyment and appreciation where the environment is beautiful and life is serene, and with esthetic repulsion and depreciation where life is troubled, nature morose and hard. But in the degree in which the active conception of knowledge prevails, and the environment is regarded as something

that has to be changed in order to be truly known, men are imbued with courage, with what may almost be termed an aggressive attitude toward nature. Conditions and events are neither to be fled from nor passively acquiesced in; they are to be utilized and directed. They are either obstacles to our ends or else means for their accomplishment. In a profound sense, knowing ceases to be contemplative and becomes practical."<sup>3</sup>

In those easy days of contemplative knowledge, the learned Diogenes out with a lantern searching for an honest man was probably a stimulating sight, but today, with science busy forging tools for the transformation of the world, Diogenes, to attract attention, would have to discard his lantern and apply his learning to the creation of an honest man.

Whatever the past may have accepted as adequate practice, the present, as a universal practice, is increasingly requiring that the hands be directed by their owner's head. In the November issue of the *Vassar Quarterly* appeared two articles that give evidence, approached from different angles, of this fact. Under the title, "Do College Women Believe in Education?" Dr. Spalding of Yale deals with the question of a democratic use of education, while under the title "Workers' Education," is presented the effort of the workers to develop a program of higher education for themselves.

When, beginning with the kindergarten, we cease to teach competition for possession or advantage over others, and teach cooperation for a project, the carrying out of which calls for the creative ability of each, the new education will be assured.

Without perhaps a full awareness, the community is embarked on a great project, the creation of a one hundred per cent perfect human machine through which that energizing current called life can function to its greatest ends. Knowledge too precious to be put to such uses through every available human instrument should find its place with the jeweled crowns of discarded monarchs in the locked glass cases of a museum.

When the public grasps the fact that we are not seeking to elevate nursing into an aristocracy of learning, but to apply all available knowledge to this project through the nurse, numerically so strong a factor in the undertaking, there will no longer be this effort to cramp and

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2. Veblen—The Instinct of Workmanship and the Desire for Excellence.

3. Dewey: Reconstruction in Philosophy, p. 116.

stultify her education. And when the doors of knowledge are freely opened, students will awaken to the import of the nurses' task and will flock to our schools of nursing in far greater numbers than before.

THE CHAIR: I am sure your applause has conveyed to Miss Goodrich your very deep appreciation of her address, and certainly, if there is any doubt in the mind of anyone that public health training should be included in the training of the nurses, Miss Goodrich has removed it. These papers have dealt with remedies for the ills that exist in our training schools, and, if followed out, we would have a very much better existence; but no matter how perfectly we develop our training, we must have students to carry it out. Miss Hall, superintendent of nurses in Quebec, will tell about the plan that has been worked out by the three national nursing organizations of the United States towards this very thing, that is, a plan for the recruiting of student nurses. Miss Hall.

MISS HALL: It is a fact that young women, in applying for admission to schools today are becoming very discriminating and asking superintendents all these questions and more, and it is only recently that I had the experience of having a young woman come in with a notebook in hand; she interviewed me, I did not interview her, and she asked all these questions and more, and she asked whether we had self-government or still had military rule. Then, on the back of this leaflet in my hand is also outlined some of the opportunities that await the nurse after she has been properly trained. This sheet is also a part of the literature which has been provided by our national headquarters, and is called "A request for information." This is to be widely distributed in communities to young women who may become prospective applicants. It provides a form on which they may write to training schools, asking for application blanks and information. Below it are two sheets to be torn off and returned to the national headquarters, so that eventually national headquarters may have some definite idea about the result of this campaign. This campaign and these committees are to work for an indefinite period of time, but it is hoped that the work will begin very shortly; in fact, it has already begun. That body of people known as the public is the group which is suffering most from the shortage of nurses. Up to the present time the training school superintendents have always borne the brunt of the battle to secure a sufficient number and the right type of

young women for the schools. The nurses are still ready to take the lead in this matter, as shown by the movement on the part of our national organizations. The pupils themselves, however, must come from this same group, the public, and so we now look to the public for a very large share in helping us in the solution of this problem.

THE CHAIR: I think we are particularly fortunate in having Miss Hall present tonight, because very soon, as she has said, the campaign will be launched and you will be asked to help. That completes the papers on our program. We will now have the discussion, and to facilitate that, we have arranged for two or three who will begin. We are going to ask Miss McMillan, director of the training school of the Presbyterian Hospital, Chicago, to discuss the question of the improvement, we might say, in teaching, or the changes that might be effected in teaching, that will improve the courses in our schools.

MISS McMILLAN: In opening this discussion, I want to say that the most important point in our schools at present is to make them educational. Those of us who have been receiving letters from young women in the country during the last month have come to believe that women are essentially interested in taking up nursing. We get letter after letter from young women saying, "We want to be nurses; we hear that your school gives an excellent education. May we enter?" The question of education seems to be uppermost in their minds; they do not ask you, usually, how long is the course or whether they are to receive any remuneration or what is the length of the hours; they say they want an education. That is also, I think, borne out in an experiment which was tried during this summer in one of our schools. The young women student nurses in the school were requested to write letters stating what, in their opinion, was the better thing to do, to reduce the course of instruction to two years or to maintain the course at the three year period. With very few exceptions, they responded very promptly; some of them were most anxious and earnest about it. One young woman wrote immediately as soon as the request was made. She said: "I think it is unfair for the National League of Nursing Education to invite young women of the country, to persuade them to go into nurses' schools, and then to consider lowering the standard of nurses' schools and adopting a two years course."

THE CHAIR: I ask Miss Mary C. Wheeler, of the Illi-

nois Training School, to discuss Miss Claribel Wheeler's paper on hospital helpers.

MISS MARY C. WHEELER: In regard to the matter of hospital helpers, I wish to say that we have been trying this for some years at the Illinois Training School for Nurses in Chicago. We have had quite a number of attendants, as we call them, staying with us since, perhaps, 1908, and some since 1910, and they have become invaluable in certain places in the institution. For instance, the woman who attends to the care of our rubber gloves could not be duplicated in any way by the student nurse. Another woman has become really a specialist in the x-ray department, taking over that entire piece of work. Another woman has become very useful in the cystoscopic department. Others are in the children's ward and general hospital service, taking care of the diets, etc., doing an excellent piece of work. We have also clerks in our ward who take care of the telephones and messages. Sometimes the number of student nurses is very low in comparison to the number of patients we have, but that is due to the fact that we have utilized outside resources in many respects. We have not given a definite training; I do not know that we are ready to do that, but in various departments they have proved extremely helpful.

THE CHAIR: That completes the discussion that we had arranged for. We are now ready to hear from the floor. I must suggest that it is getting late, and the discussion will, of necessity, have to be brief.

DR. MUSE, of Baltimore: We must make nursing more attractive; we must not lower our standards, but we must be careful about making it too hard for the girls who want to serve humanity. There are many young ladies who have not had college courses but who have the intelligence, the natural wisdom of the real woman, who want to serve humanity, and no man or woman was ever happy who did not serve humanity.

I am reminded that in the neighborhood in which I live in Baltimore, all during the last summer, when children were out playing, I remember seeing only one single little child under seven years old on the street within three blocks of me. Won't you take that, you ladies interested in public health work, you nurses who are visiting the homes, you know that this condition exists. Find out who the owner of the apartment is and shame him. If he will not listen, go to your representative in

the legislature for that district and shame him, and if he won't listen to you, vote against him. (Applause.)

MR. TECK, of Vancouver: I rise not to attempt to discuss the paper and the discussions we have heard tonight by such eminent authorities as have spoken, but I do think we cannot leave this important meeting without briefly summarizing some of the effects to carry away with us. First of all, I want to urge my fellow hospital administrators to make sure they take stock of themselves and are giving the training school the interest and thought and attention they should; make sure, by the way, that after this you call at the office of your superintendent of nurses or director of nurses each day and ask her, "Is there anything you want to see me about today?" The fundamental thought, of course, all the way through the talks tonight is, how we can produce more efficient nursing for our patients, not only in the institutions but in the homes, and how we can supply the public health service demanded in our community by way of preventive medicine, and all this seems to hinge on the shortage of nurses. Now I will summarize what occurred to me while these papers were being read, as to remedies, and I have added a little to it that the speakers tonight were not able to cover. First of all, better working conditions for our nurses. By that we mean shorter hours. Everybody should go home and try to install the eight hour system, if you haven't it in your hospital now; the relieving of the nurses of the menial work in the ward, which has been mentioned tonight, whether by ward attendants or by maids. Secondly, better living conditions. Thirdly, better social conditions, better life, a more attractive life for our nurses, but, more important than all, possibly, that at present much neglected subject, better training conditions.

THE CHAIR: It seems to me that we are very much indebted to the speaker for summing up the discussion tonight. Is there any further discussion?

DR. BUNTS, of Cleveland: I have listened with admiration to the brilliant and enthusiastic addresses which have been made this evening by some of the most distinguished speakers of the nursing profession, and it would be far from my desire to cast a discordant note on the program which has been laid before you, but I have listened in vain for a note on service to the sick. I regret to say this. I have heard, and I believe thoroughly in what has been said, about the importance of public health nursing.



There is no doubt in my mind that the vast importance which this bears to public health, or that the healthy man is one of the greatest assets which the government can furnish or assist in furnishing to its people. But there is something more needed. How is it to be done? We must leave that to those who are leading your profession. But we who work with the sick must have help, and I just leave it as a thought, perhaps to all of you, that while hundreds, thousands, of nurses are needed in public health work, and are demanded on all sides by industrial institutions, that in the homes of the wealthy and the middle class and the poor are sick men and women and children who need care. If the education which you give to these coming nurses is to be such as to make them feel that nursing in its true sense, as we used to know it, if that kind of nursing is to be abolished, if, as the leader of the Red Cross nursing institutions, I think, in Cleveland, told me, that the day when nurses would go out for weekly and monthly nursing was fast passing, I asked, "Why, if I am sick, I'd want a nurse." There is no one who has a greater admiration, who has seen more of the sacrifices of nurses at home, in our hospital, in our camp hospitals, among the wounded and sick in France, than myself, and I yield to none in my admiration for the services which they have rendered, but when they tell me that hereafter—I hope it is not the opinion of those distinguished nurses who are leading the profession—that they will no longer minister to the sick except as visitants, that the routine work must be done by the mothers and sisters and cousins. Those of you who are doctors, those of you who are nurses, know that ministering to the diseased is one of the greatest functions you have, and when I am sick and restless and weary and worried, the thought that there is an intelligent trained nurse in the room to watch me when I sleep or when I am delirious, and that I am not obliged to leave it to someone who is unintelligent, is one of the greatest comforts in the world. Unfortunately, not everyone has a mother; some of them have gone where they will need no more nursing; they have not all sisters; they have not all cousins who can be called in or who can be trained, and many of the women, even if they could be trained, have occupations, some of them have to help earn a livelihood for their families, they have their own cares in bringing up their babies and children, getting them ready for school and making their garments. We

must have nurses, and I just want to say, in closing, that in the name of your mothers and your sisters, your fathers and your brothers, your husbands and your wives, in the name of humanity, give us nurses to take care of us.

MISS GOODRICH: I feel that I must answer, if I can, one word of the Doctor's. I would feel that I had utterly failed this evening, if I have given the idea that the woman we will call a nurse was no longer going to render you medical care. My point is that by virtue of the remedial care she renders, when she goes into that family, there is some way in which she can prevent the recurrence of the situation she finds, either with that particular patient or others, she should render that service there. That means a greater amount of education than is required simply for the bodily care of that patient. Now I did not know, and I have been thirty years in nursing, I did not know until a few years ago, that it was quite a customary thing for the children in the poorer sections of the city to have pneumonia two or three times in a winter. I feel today that the nurse who goes in and takes care of a case of pneumonia in that family and goes out and comes back again and takes care of the child again, this time a little worse off, and the third time probably sees it die, has somehow failed in that first case, or we have failed back of her if we do not get to it and see to it that we remove the conditions which gave that child pneumonia three times, when, in the homes of the well-to-do, the wealthy, rarely, if ever, in the homes of the well-to-do, almost never, do we find the same child having pneumonia twice in a winter.

THE CHAIR: I am sure we could continue the discussion indefinitely, because there are so many points that could be brought up, but it is now nearly eleven o'clock, so we will have to adjourn.

AMERICAN HOSPITAL ASSOCIATION  
SECTION ON HOSPITAL CONSTRUCTION

Montreal, October 6, 1920, 8:00 P. M.

Dr. George O'Hanlon, Chairman, Presiding.

Mr. Oliver H. Bartine, Secretary.

THE CHAIRMAN: The meeting will please come to order.

Your Committee on Hospital Construction has held various meetings throughout the year, and has taken into consideration in preparing the program for this meeting, the existing conditions with regard to labor, building and materials, and so forth, but thought it was better to limit the matters presented to one paper, and a round table discussion of matters that we are all particularly interested in, especially those of us having these problems to meet.

A request was sent out that any questions any of you were particularly interested in during the session should be presented to the committee, and they will be presented tonight. There were a number of responses, and we will present them to you in the order in which they seem of the most importance to the committee.

We are asked for particular and free discussion, but should there be any other questions uppermost in your minds, you will have an opportunity to present them, and I hope you will feel free to get up and give us the benefit of your experiences in this matter.

The paper of the evening was to have been read by Mr. Frank Chapman, superintendent of the Mount Sinai Hospital of Cleveland, Ohio. I regret to say, as perhaps some of you know by this time, that Mr. Chapman is very ill, and confined to the hospital, and his paper will be presented by Dr. Bachmeyer, superintendent of the Cincinnati General Hospital.

DR. BACHMEYER: In a development of the construction plans of a hospital, the variety of phases to be considered are infinitesimal; but there is no one phase more difficult of correlation, no one phase meaning more to the future economical and efficient operation of the hospital, than the proper planning of the dietary department, taking into consideration the preparation and serving of food. By reason of the fact that the dietary department has by far

the largest individual budget of any department in the hospital, and that the physical layout is responsible to a large extent for its efficient or inefficient performance, then, too much care cannot be given to the proper planning of this activity.

It must be borne in mind that the institutional feeding problem is a rather complex one, covering serving of food to private patients, to ward patients, and to the hospital personnel, necessitating a very careful consideration of the methods of service in conjunction with preparation. A very common mistake is that of planning the dietary department and then attempting to fit a service to this plan, rather than approaching the problem in the logical way, by first determining the character of service and then fitting the plan around that type of service.

The centralization of all preparatory service is of course by far the most economical, and if it is possible with the type of institution to prepare and serve the personnel of the institution from the main kitchen, it should be done. However, there are certain developments in which this is not possible.

The location of the main kitchen is of paramount importance. There are three general locations: the top floor, the first floor, or in a separate building.

There are some few types of hospital buildings that lend themselves to a top floor kitchen development, but the scheme in general should not be encouraged. The top floor of a building is unquestionably the best floor for patients, and unless there are some unusual conditions that make a portion of this floor available for kitchen purposes better than for patients, this location is not advocated. In addition is the problem of transportation of such supplies as coal, groceries, ice, etc., and returning garbage, ashes, etc. In favor of this location, of course, is the fact that the odor from such a kitchen is less objectionable; but after all, if a kitchen is properly ventilated, this nuisance can be reduced to a negligible quantity. In a small hospital, unquestionably the best location for the kitchen is on the first floor, as near to the center of activities as possible, in order that the travel of food may be reduced to a minimum. The separate building for the large institution is very desirable, provided it can be properly correlated. Careful consideration must be given in any location to see that it will be possible to transport the food quickly and with a minimum loss of heat in transport.

Very little, if anything, can be said as to the size of the kitchen, this being dependent entirely upon the type of institution, the proportion of private to ward beds, etc. By all means, the size should be developed from a very thorough knowledge of the service to be performed, bearing in mind that unnecessary space necessitates unnecessary labor. If at all possible, and the desirability of making such a scheme possible is very great, the kitchen should be open on three sides. The ventilation of a kitchen suite is rather difficult at times. The efficiency of hoods, ranges, stock pots, etc., is a mooted question, and unless such a hood is supplemented by exhaust fans, both in the stack and in the hood, and in the openings in the kitchen proper, they are of very little value.

Too much attention cannot be given to this question of ventilation, nor the question of light. The walls should be of white tile if possible, not only for cleanliness' sake, but for the sake of better lighting.

The type of floor is important from a housekeeping point of view. Red quarry tile makes an exceptionally good floor. It is expensive, but the necessity for providing a floor that can be easily cleaned, and one that will wear well, indicates a very careful consideration of such a floor, or a floor of similar type.

For hospitals of one hundred beds or over, unquestionably there should be furnished separate pastry rooms, sculleries, meat and vegetable rooms, and cold and dry storage. With large units, additional rooms are indicated. The policy of having one room for the entire kitchen activity tends to confusion and is not productive of the best results.

By far more important than the actual equipment is its proper installation. A very efficient piece of equipment may lose its entire value if placed relatively in the wrong position in the activity. The whole kitchen operation should be studied with an institutional performance in mind, laying out the unit to permit the easiest possible performance. Hotel installation is not a good example to follow. The service required of a hotel kitchen is entirely different than that required of a hospital kitchen.

The installation of hoods over as much of the equipment as is possible is very desirable. This not only takes off odors, but has a very salutary effect on the temperatures of the room, provided these hoods are properly connected up.

Too much emphasis cannot be placed on the installation

of as many labor saving devices as possible. These not only conserve labor, but they insure economy in the distribution of foodstuffs. Claim is made that a bread cutter alone will pay for its cost within a period of six months, in the uniformity of slices and in the increased number of slices to the loaf. It is questionable whether this statement can be successfully debated. Meat cutters, butter cutters, kitchen machines, meat slicers, vegetable peelers, and sundry other devices will be found of inestimable value in the operation of a hospital kitchen.

There should be a cook's refrigerator of sufficient size to take care of working supplies and leftovers. The type of cook's table to be installed is dependent entirely upon the character of service. Moderate sized steam tables are desirable at times. In any event, this type of table should be of a simple and sanitary construction. Dependent upon the size and character of the institution, should be installed stock pots, cereal cookers, vegetable steamers, meat roasters, etc.

The range should be preferably a French top range, with no shelves to collect dirt. The oven capacity should be large; many are too small. In some types of services, broilers should be located in the main kitchen; in other types, in the diet kitchen.

The item of plumbing in the kitchen is a very important one. Care should be exercised to get sinks at the proper height from the floor, in order that the preparation of vegetables and washing of pots and pans may be done with the minimum of expended energy.

The question of open shelves or closed cupboards is a matter of personal preference. In any event, these cupboards or shelves should be adequate in capacity and easy of access.

The elevator service should be given very careful consideration. It is highly undesirable that foodstuffs be handled on the regular passenger elevators. By all means, electric dumb waiters should be installed, if dumb waiters are indicated. The personnel should not be compelled to labor with the hand operated system. Dumb waiters as usually installed are not sufficiently large to accommodate food carts. If food cart service is to be used as a routine, care should be taken to see that elevator service adequate to take care of these carts is installed in duplicate, in order to insure a continuity of service.

It will be noted that no provision is made for steam tables. It may be possible to operate such a table with



satisfactory results, but I have failed to see it done. In my opinion, it is wasteful and responsible for a larger percentage of the complaints against the dietary department than any one other agency.

The special diet kitchen should definitely be a part of the kitchen activity and should be so located as to permit of easy supervision on the part of the dietitian. The same comments pertain as in the main kitchen. This room should be sufficiently large to permit of an efficient operation, depending entirely upon the type of service and the size of the institution. It should be equipped with stove, broilers, dish warmers, sinks, and cupboards. It would also seem, in an institution in which a large number of infant feedings are prepared, that facilities should be provided for a room which can be used for the preparation of special formulas. Such a room need not be very large, but should be so constructed as to be easily cleaned and ventilated.

The ward serving room is a very important unit in the dietary service, and should be given very careful consideration in planning. Its location should be near the center of the unit that it serves, in order to reduce to a minimum the amount of effort necessary to serve trays. It should be planned so that the elevator service should either come directly into this room or be very closely adjacent thereto. The flooring should be of a type that is easily kept clean and is non-absorbent. A fair size for a room of this character should be ten square feet per patient to be served, with a minimum of 150 feet floor space. The necessary equipment in such a room should include a refrigerator, a dish sterilizer for contaminated dishes, dish warmer, toaster, sink (double sink advocated), garbage receptacle, towel rack, cupboards, a tray rack of sufficient capacity to hold all the trays to be served, and a large work table with drawers.

The feeding of hospital personnel is an exceedingly difficult problem, and one that requires very close study to be satisfactorily worked out. In all events, the dining and service room should be located away from that part of the hospital containing patients, and should be varied in size and character, in order to serve the various classes of hospital attachés. As a minimum list of the types of dining rooms, the following is submitted: officers, interns, nurses, special nurses, office attachés, orderlies, domestic help.

A great many institutions have adopted the cafeteria

method of service. While it is true that this is economical, and offers some very definite advantages over maid service, it is questionable if it is a desirable service. The hospital dining room is one of the few places of relaxation for the personnel of the institution. Most of these people have no other home than the hospital, and certainly standing in line for three meals a day, 365 days a year, has not the tendency of creating the homelike atmosphere that is desirable in a hospital. In any event, the location and equipment of serving rooms is dependent primarily upon the type of service that is to be rendered. If there is cafeteria service, the arrangement of commercial cafeterias may be copied, bearing in mind, however, that there will have to be at least two, and probably three, different serving rooms to take care of the various classes of attachés. It is extremely undesirable, in fact almost impossible from an administrative standpoint, to have all groups supplied from one serving room.

Food may be conveyed to patients by several methods: It may be taken by heated food carts, heated by hot water jackets or by electrical elements. This method is in very common usage. Such a cart has some very definite advantages; but it has one distinct disadvantage, *i. e.*, unless the food is handled very promptly, the injection of this additional heat in transit has a tendency to change the character of food by cooking it over and above the palatable state. This equipment does not, however, provide for the handling of cold foods, such as salads, desserts, etc. A new device on the market is a food cart constructed on the principle of the fireless cooker or vacuum bottle. The most perishable of foodstuffs placed in this cart will retain its character and heat for several hours. Mashed potatoes can be kept for eight hours, without changing their palatability or temperature in the least respect. This equipment, from personal experience, is submitted as the most efficient method of transporting foodstuffs. A detailed description of this service may be of interest, and will be given if desired.

In conclusion, there is one primary thought that it is desired to convey. The best of raw material improperly prepared and improperly served is rank extravagance. If it cannot be placed before the patient in a condition to be eaten, it might better not have been cooked. The great trouble with hospital dietaries is that foodstuffs are primarily prepared with facilities that have not been planned for the service; and as a consequence the food is handled

so many times that it is bound to be cold when served. In the planning of a hospital building, the importance of the dietary department should not be overlooked. It should be studied just as carefully as one would study the location and equipment of the operating room suite, and the result obtained will more than justify the efforts.

THE CHAIRMAN: This very interesting paper of Dr. Chapman's is now open for discussion, and I would ask each speaker to announce his or her name distinctly so that the stenographer will get it on the record.

DR. BRODERICK: I would like to give serious discussion to the matter of the location of the kitchen. I felt for many years that the kitchen should not be located on the upper floors, owing to the objection that has been raised by the speaker, and that is to say the transportation of food and fuel, removal of swill, and so forth, but I have come to the decision that there is no better place for the location of the kitchen than on the top floor, and that the objections raised are not material as compared with the tremendous advantages that have been discovered in the removing of odors and noise, and giving the advantage of a sunlighted, airy kitchen.

Now, as to the matter of fuel, in large parts of the United States, we are using oil, and preferably gas, and certainly that removes that element entirely. In the matter of the removal of garbage and swill, many of the hospitals are planning their vegetable rooms for the preparation of vegetables and so forth, and even to the extent of having a steamer room below, and simply basketing the cooked vegetables up to the kitchen as required.

In the matter of equipment, I am sorry to hear the speaker is not an advocate of the steam tables or the hot top tables, and I listened with a great deal of interest to his objections. The proper preparation of food for the patient in the hospital requires that the food should be kept as hot as possible, and it seems to me the best way to do that is by use of the steam table. Now, the use of hoods: The average hood becomes a great fire menace by reason of the collection of dirt that cannot be adequately cleaned. I am very much interested in the advocacy of the wire-bound glass hoods, with nickle trimmings. This permits the sunlight to come through.

I was also interested in hearing the speaker refer briefly, but unfavorably to the cafeteria service. I think much of the objection to the cafeteria system will be

eliminated if we have a serving room separate and distinct from the dining room.

The conveyance of food from the kitchen to the wards in a large hospital is probably one of the most important functions the hospital is called upon to perform. The heated food carriage is absolutely antiquated. It is heavy, it is never really hot, as we are only deceiving ourselves to think it is. The food carriages are very heavy and one that I had weighed some little time ago was found to weigh about 1,200 pounds, which is a tremendous factor in elevator service. The fireless cooker is unnecessary, and I think the whole solution is the quick transportation of food in a heated condition in hot inserts of large size, from the main kitchen to the various wards and private rooms of the hospital.

DR. RICHARDSON: I have been looking for some kind of a container which seems to me entirely feasible, built on the principle of a thermos bottle, and a carriage that will carry these, so that we can take the food from the kitchen to a ward of from twenty-five to thirty patients. If we could find something of that kind, and by putting a cover on it, we could keep the food hot until it is delivered to the bedside, I am sure it would be a great advantage to any hospital.

DR. CRANE: Just as a matter of information, the community kitchens of Evanston, Illinois, have been studying this proposition and they have started on a solution which I think and hope will be feasible. The cooked food is sent out from these community kitchens, a considerable distance, and in some cases a mile or more, to the homes of the people who are buying the service. They do not use conveyors, but they use single vessels which are somewhat of the type of a vacuum bottle with section to contain the meats and vegetables and other things, and they say that it works fine.

THE CHAIRMAN: The meeting is now open, and we will be glad to hear from anybody who desires to say anything on this subject.

DR. STEVENS: I am particularly interested in the remarks of our friend from California in regard to the use of oil in the kitchen. I have never seen that used anywhere except in his hospital, but it struck me at that time as something which we might use very easily.

Referring to Dr. Richardson's inquiry about food carriers: I find in studying the hospitals of Europe, many of them even ten years ago were using carriers of that

kind. The food was placed in various compartments in these cans, and placed on a carrier and carried over-ground to the various wards. In one hospital they use a trolley car in taking the food from the kitchen to the various wards, probably a quarter of a mile in distance. The attendant who was showing me about the hospital said that they received hot food within five minutes of the time it left the kitchen. I know these insulated carriers are used in New England, in the community kitchens to which reference has been made.

THE CHAIRMAN: Is there anybody else to contribute to this interesting discussion?

DR. BACHMEYER: We carefully planned out the steps the people in the kitchen were to take in going from equipment to equipment, and we tried to conserve their energy and time, and we have a kitchen there now in which the personnel is very much reduced, where three cooks can do the work it used to take six in the other kitchen, because of the way the kitchen was arranged. Instead of giving a cook three or four feet in back of him, we limited him to about 30 inches, so instead of taking three steps, he can turn around and reach anything off the table.

THE CHAIRMAN: It came to my attention a few days ago that at the extension course of household economics the first lesson was to draw their idea of a model kitchen, and the second lesson was a practical application of that kitchen. The professor, with the drawing of each model kitchen before him said, "We will now proceed to follow a potato." So they started with a bag of potatoes in the kitchen and took them to the sink and washed them and then they went to the pantry to get the utensils in which they were to wash them, and take them to the sink, and they then peeled the potatoes and they said, "Now, of course, we have to salt them, too," and they went through the operation of salting the potatoes and they took them to the table and removed the peelings and prepared to cook them, and in doing that they found that in each one of these model kitchens they had to retrace so many steps that the model kitchen of each one of the class of thirty was no longer considered a model.

In planning a hospital there seems to be a very important department that is usually overlooked, and that is the social service department. I will ask Miss Antoinette Cannon of Philadelphia to open the discussion on this subject.

MISS CANNON: We have had all sorts of experience in

trying to stow ourselves away in the various corners of the hospital, which have been offered for the housing of the Social Service Department, and we found that in spite of the apparent advantages that we have been able to adjust ourselves to all sorts of conditions, notwithstanding, I believe we all have our ideas of what we would like to have in the way of improvements.

The hospital, in providing places for the Social Service Department, should plan to give at least one office for the executive, or an office for each executive if there be more than one. I do not believe that the staff workers of the department need to have separate rooms. In planning for the dispensaries and clinical departments, it should be taken into account that some place must be provided for the social worker where they can interview the patient privately. I do not mean necessarily in a separate room. I want to make the point there should be provided ample places for the storing of records where they can be locked up when not in use, and at the same time accessible to the members of the department. I do not believe any Social Service Department has ever had any really good facilities for keeping these records, and I have heard of at least two departments that were forced to destroy their old records at certain periods because they did not have any place in which to keep them. Such a process is nothing more than a tragedy. The records are certainly of value to the social workers, at least in the study of their own work, and they certainly ought to be of value in connection with the medical history of the patients.

The office of the staff workers, or the room which the staff workers use, ought to be accessible to the dispensary. The workers have to meet the patients in the dispensaries and the wards, and the dispensary patients come to the office. The ward patients are visited in the wards, so if it is a question of being accessible either to the wards or the dispensaries, the choice ought to be accessibility to the dispensary.

THE CHAIRMAN: I will ask Dr. Richardson to continue the discussion. She has had a good deal of experience in making surveys of social service work. Will you give use the results of your experience, Dr. Richardson?

DR. RICHARDSON: I have recently had the experience of surveying about sixty of the social service departments, and I can tell what their problems are under the present system. The most serious condition is the crowding. Thirty-seven of the departments were so crowded that in



many cases two workers had to use the same desk, at different times, and in other cases they were so close together that they are hindering each other continuously. This is certainly a distinct disadvantage in the type of work which they have to do.

I know of one department where there are fourteen workers and four stenographers in one room. The room is about 15x16 feet. It is quite a high room, but the floor space is so crowded that it is almost impossible to do good work.

Another problem is the lighting of the room. Ten of the departments had their rooms in basement where they were very inadequately lighted, so the workers had to have artificial light.

THE CHAIRMAN: We will be glad to hear from anyone else on this subject, or any person having a question on the social service department.

MR. PILGRIM: Social service is one of the greatest parts of the work in connection with the treatment of the poor patients. It seems to me that poor patients have as much right to privacy as the rich ones, and when you ask them questions in reference to their poverty it should be between you and them, and the social service worker should be enabled to handle individual patients, and she should have a cubbyhole where she could handle them privately, and not have another crowd of poor people.

MISS POOLE: Now, the department in our new hospital will consist of an admitting room where the secretary of the department will stay and interview the patients. There will be a private room for the executives; there will be another room for the assistant; there will be a large staff room, and on the other side of the large staff room there will be another small room for the convenience of the service, and there will probably be one or two smaller rooms across the corridor.

DR. SEYMOUR: In these days of the high cost of building hospitals I would like to have the opinion of Mr. Stevens, of Boston, and some others who have given consideration to the question of cubic space per patient, floor space, and the height of ceilings. In a great many of the old hospitals, ceilings were built at what I considered an unnecessary height, I have even seen them up to fourteen or sixteen feet high, and I would like to have the opinion of some of those who have given consideration and thought to air spaces as to what they consider

the proper height, and the proper floor space, in the various wards.

MR. STEVENS: It seems to me that a reasonable ward, a height beyond twelve feet is, at least in the central climate, a waste of cubical contents.

As to the type of ward, I have used what I am calling the Riggs ward, because I first saw that used at the Riggs Hospital in Copenhagen, Denmark. It was a sixteen bed ward, and contained an area of 40x40 feet, divided into four sections, with fine screens placed part way across the room from side to side, so that the heads of eight of the beds were going against that screen and the other eight beds against the end walls. That placed the sixteen beds so that no patient lying in bed would look into the light, or look into any of the windows. The windows would be made large, so that the sunlight would come to the side of the bed, and not directly in the eyes of the patients as would be the case if the beds were laid out in a different manner than what they were. So, on an average, let us say that a twenty foot ward, where the beds would be in line on either side of the room, is about what I consider the proper thing. This worked out in a number of cases very satisfactorily. Personally, I believe that we are getting to smaller wards, perhaps the smaller the better.

I do not think that we should have less than one thousand feet of air space per patient, but in a private room it works out a little more, making the room perhaps 12x15 in size, and with its cupboards for the patient's clothing.

THE CHAIRMAN: Perhaps you will answer this: What is the ideal floor basis for hospitals?

MR. STEVENS: I can only answer that by giving my personal experience, but I have used most everything. What I consider the most ideal, that is, what I use generally, is the terazzo, or some material of that kind. Possibly Portland cement, if we cannot go to the expense of the terazzo, and make that base on the same line as the walls, that is making no projections, and with the corner of the wall and the floor making a shoe, or else making a footboard projection so that the bed, or the furniture, or the tables will be kept away from the walls. This furniture shoe should raise perhaps three-quarters of an inch, and project three inches, because it does not hurt the looks of the rooms in any way.

DR. BRODERICK: Mr. Chairman, may I say just one

more word? With regard to the matter of the size of the ward, I feel that we all are coming in our opinion to the smaller wards, but that does not mean that the ward should necessarily be of four to six beds. I think the ideal—and I am speaking of the larger hospitals—I think the ideal size of the wards as a whole is probably around twenty-five beds. I think that works out better for our personnel, especially for the nurses' personnel. It gives probably the most efficient organization in a large hospital.

THE CHAIRMAN: Before adjourning the meeting, I would ask Mr. Bartine to say something to you on the question of the floor basis construction, and after his remarks I will consider this meeting adjourned.

MR. BARTINE: The chairman misunderstood me. I wanted the question presented to find out if there was anyone here to discuss this problem. Mr. Bacon is an advocate of the abolishment of private rooms. It is maintained by the authorities of two New York hospitals now planned with rooms only—no wards—who are vitally interested, that the hospitals can be operated economically or nearly as economically so constructed as under the present system of caring for the patients, namely in larger wards. My own object in speaking to the chairman was to find out if there is anyone who could enlighten us in that direction. Perhaps Mr. Stevens could do that.

MR. PILGRIM: Mr. Chairman, could we get Mr. Bartine to get us the results of his experience? If he will be able to open his hospital—could we have this information at the next convention?

THE CHAIRMAN: The two hospitals are the new Fifth Avenue, and the new Beth Israel hospitals. I think it would be a good idea to have enlightenment as regards both of these hospitals at the next convention.

DR. SEYMOUR: I would like to ask in regard to the shortage of nurses, what number of patients is generally assigned to each nurse.

THE CHAIRMAN: Does anyone here feel that they are competent to answer that question, how many patients can a nurse properly care for?

DR. NASH: In private wards it is criminal to have less than one nurse to each room. She can take care of one patient in a private room. If I had my way, I would declare that the private rooms are the curse of all the hospitals.

DR. SEYMOUR: How many can she care for in public wards?

DR. NASH: Six or eight if necessary.

MR. BARTINE: In answer to that question, it is maintained by the authorities who are interested in the construction of single room wards that they will not require any more nurses to care for a given number of patients than they require today.

MR. PILGRIM: In reply to the last question, I have heard it said that the policy of a certain superintendent was that the lowest number of nurses of a well conducted hospital, should be one nurse to every two patients.

DR. WILSON: I was interested in Dr. Nash's statement that he thought that single room wards were unnecessary. It just happened that I have a good many dozens of such rooms, and I do not like to feel I am in the criminal class. I would like Dr. Nash to illustrate.

DR. NASH: I will certainly be glad to. The only thing that keeps any man in the straight and narrow way is the public gaze. The only thing that keeps a nurse in the straight and narrow way, especially under the present system of nursing, are the eyes of others. You have the single system because they are under supervision, because there are eyes over eyes. That is a matter of safety. This you cannot have if you have a nurse for every two or three rooms, with several patients to look after. In my experience I find that they were not caring for the patient as properly as they could be, and not giving them the attention that they would in the wards. I will repeat that it is almost a crime to put patients into private rooms and give one nurse three or four or five rooms to look after. That is where your accidents occur. The nurses are only human. If you have a patient who is really sick, you are up against it, because no nurse has the time to give her undivided attention to that particular patient.

Gentlemen, I say to you that the private room business is criminal, unless there is a private room nurse for every patient in a private room.

DR. WILSON: What the doctor said about the danger of leaving seriously ill patients in a room is a very well taken point. The patient taken from the operating room after ether is liable to turn over and smother. There are very many cases which are sick, are so sick that you should not leave them alone very long, where an open ward would seem to be preferable, or a semi-private ward.

The Willard-Parker Hospital in New York has a four foot glass between every room. You can stand in the end of these private rooms and look from one end to the other. They are really separate rooms, as you can close those windows and many of them are closed from time to time, but I must say that, from my own standpoint, we get more satisfaction out of these private rooms than we do in any other side of the hospital.

Personally, I think that no hospital ward should have over ten beds. I do not care whether a general hospital or a special hospital, it should not have over ten beds, and preferably it should only have five beds—a five bed ward. That is, if you can work it out that way, but I do think that this form of construction, where you can look into your wards is very convenient and very satisfactory, and is economical frequently in the question of nurses, especially where you have a large convalescent service.

THE CHAIRMAN: May we hear from one of the ladies in answer to this question, as to the number of patients a nurse can properly care for?

DR. NASH: If you will permit me just one word. The question is asked, "How many?" The ordinary ward at home has twenty-four beds, which usually will run twenty patients. We have a supervisor who is a graduate nurse; three pupil nurses, and in one of the wards there would be a maid, and in the other ward there would be an orderly, and we get, as we believe, very good service.

THE CHAIRMAN: Is that a day and night service?

DR. NASH: No, sir. That is a day service. It is from seven to seven, unfortunately. At night we have on the floor where there are two wards a number of private rooms, one supervisor and four nurses on duty. We also have one orderly. We have no maid.

The meeting adjourned.

## AMERICAN HOSPITAL ASSOCIATION

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, Canada, October 7, 1920, 10 A. M.

President Howland in the Chair.

THE CHAIR: The meeting will please come to order.

MR. WRIGHT, of Cleveland: In order that the full value of Mr. Pliny Clark's excellent paper be not entirely lost, I move that the incoming President be authorized to appoint a special committee to study the subsidy system as suggested in Mr. Clark's report, to make a report, with recommendations, at such time during the year as the committee sees fit, to the Board of Trustees, and to make a report, with recommendations, to the next convention.

The motion was seconded and unanimously adopted.

THE CHAIR: The first paper this morning is "Function of the Social Service Department in Its Relationship to Administration of Hospitals and Dispensaries," by Miss Ida M. Cannon, President American Association of Hospital Social Workers; director, Social Service Department, Massachusetts General Hospital, Boston, Mass.

MISS CANNON: I have come today not to present a formal paper but rather to throw out some suggestions to indicate some tendencies in the growth of social service in hospitals, and to very earnestly ask the cooperation of hospital administrators and hospital social workers in looking to the future to see just what our joint responsibility is; you are all conscious that the hospital is taking on at least new points of view. The social worker, coming with a special knowledge and a special skill, knowledge of the community, knowledge of the community's resources, knowledge of human difficulties, ought to be able to contribute something to the hospital of the future; and so I want to bring to you some of the tendencies that we are seeing and to put before you, as the American Hospital Association, your responsibility and our responsibility as hospital social workers, to get the fullest value out of what we can both contribute to that future hospital.

I want to make clear at first that we believe our primary function is that of social work with patients. "Social case work" may be an unfamiliar term to some of you. I want you to understand what we mean by that.



When we speak of social case work we mean a procedure that in principle is comparable to medical case work. Case work, whether medical or social, is based on a knowledge of the condition of the patient at a given time, an interpretation or diagnosis of the condition and the formulation of a plan of treatment, a plan that looks to the future and the fullest possible restoration of the patient. In social case work we see the patient in the hospital not merely as a medical problem, but as a member of a family group, an individual with many and various human relationships, to whom this medical condition may be simply an incident in the stream of his life, and our purpose is to see that, if possible, the patient is somehow better for this hospital experience. If not better physically, better spiritually; if he is to be restored to health, better because he has a new or renewed conception of the fullness of life; if he is to be a chronic invalid, with courage to face that fact frankly and squarely.

As I am talking about the social worker, I am thinking not merely of a kindly person, who is interested in doing the friendly things that need to be done in any institution where people are accumulated. I am not speaking of social service as the "heart of the hospital." We have no claim to that. The nurses, the doctors, the administrators must exemplify that spirit in the right sort of a hospital. But I am thinking of the social worker as a person who is bringing some specialized knowledge and specialized skill to the complicated personal problems of the patient, problems that complicate the medical condition and hamper recovery. I am thinking of the social worker as a specialist in human relationships, with the community as her field and the patient in his community and family relations as her particular interest. To serve adequately the patient and the hospital, she must be endowed with some special personal qualities and trained in her field. But above all, she must care about and understand human beings of many kinds. She must have that quality of "empathy" which Dr. Southard so ably interpreted. He contrasted empathy with sympathy, as meaning not merely feeling for the patient, but the capacity of feeling oneself in the patient's place. The foreign-born and foreign-speaking patient in the hospital, who comes without knowing our language or our ways, alone, forlorn, often, of course, absorbed in his physical discomfort, needs that kind of understanding. The social worker's first task is to realize how that patient

really feels, and to get herself into the attitude of really feeling the way the patient does. She must see his situation objectively, not with the prejudice of the sick person, but with the understanding of the sick person, seeing the whole situation more truly than the patient can possibly see it while he is ill. When we lose the vividness of our understanding of the patient, we have lost, I believe, the essential capacity that makes us useful in the institution where routine of procedure and thought are prone to develop.

Some of our finest and most eminent medical men have rather resented the fact that the social worker has come into the hospital for this personal relationship with the patients. They have said that medicine, meaning doctors, cannot sacrifice that personal, human relationship between the doctor and the patient, that precious thing that is probably one of the strongest forces in the restoration to health. Let us agree that the loss of this relationship is most unfortunate, but may we not also agree that it is one of the inevitable sacrifices that has come with organized and institutionalized medicine as we now find it? The usual lack of continuity of medical service and the pressure of work on the visiting physician, as well as the impracticability of his knowing at first hand the home conditions of the patients, makes really vital personal relationship between the hospital physician and the patient very rare. I maintain that the social worker has come into the hospital because of organized medicine. And I see social work, I mean skilled social work, coming to organized medicine to restore in part that which has been lost, and to work so closely with the doctor in his case work that he is made conscious of those personal and human aspects of the patient's condition. The doctor must of necessity concentrate on the medical aspects of the case, but he should not be separated from the social side. If the treatment involves influencing the patient to change his habits or mode of life, the social worker may be the one to see that the plan is put through. But to be truly effective, she must do this in close cooperation with the doctor, her plan closely interwoven with his, so that the patient has medical-social treatment, which is an interweaving of both services, and not medical treatment here and social treatment there. Such work is possible only where there is skill on both sides, with mutual understanding and respect.

It is along the lines of medical-social case work that

the strongest departments have been developed in hospitals. It was that conception that called us, as social workers, into hospital service. We went there because we cared about using our skill to help people in adversity. And, to my mind, social case work must always be the foundation on which any superstructure of other types of social service in the hospital can be safely built, for through the realities of our social case work we are always keeping vividly before us the challenge of real service to the patients. We are safeguarded from becoming routinists since we are constantly facing final results.

Now, as time has gone on, we find that there is a tendency to draw the social worker into various administrative functions in the hospital. There are some hospitals that very definitely recognize her as a part of the hospital administration. Are they doing this because she is a person who is ready to be useful to the patient wherever possible, or is there some special reason for doing it? Personally, I believe, on knowing more and more of the problems of the hospital administrators, that there are some phases of hospital administration wherein the trained worker, because she has specialized knowledge and specialized skill, may be of definite assistance.

The specialized knowledge of the trained hospital social worker ought to include an intimate knowledge of community life, and special knowledge of the community from which the patients come, the standards of living, the varied nationalities, the chief industries, the organized agencies, both public and private, for public health and community welfare. She should have a clear conception of the relation of the hospital to these other social agencies. She should be familiar with public health and social legislation that affects individual welfare. The skill of the social worker should make these facilities of use to the patients and the hospital.

Aside from case work, social workers have been called upon to assist in some distinctly administrative functions of the dispensary and the hospital. Among these is the admission of patients. There are among the administrators many skeptics who feel that the social worker should have no concern with admission of patients, that it is entirely a medical function. Certainly the social worker should have no concern with the medical suitability of patients for admission. No one would presume that. But is the judgment of the admitting officer chiefly a medical or a social one? The superficial medical judgment is

checked up in the clinic. But the final decision as to whether the patient is economically suitable for admission, whether or not he should be admitted free, whether or not he should pay for medicine and x-rays, and, on admission to the wards, a fair rate of board—these are all decisions that assume some knowledge of the economic situation of the patient. Now there are hospital superintendents who believe that these judgments are best made by those who know something of the standards of living of the patients. Because these decisions must be rather hurried, do they not need to be based on pertinent knowledge?

Several hospitals have social workers at the admission desk. The Pennsylvania and Protestant Episcopal hospitals of Philadelphia have social workers who determine the board rate, and I understand from the superintendents that the plan is working well. The social worker at the admission desk is more common in the dispensary. The Boston Dispensary was one of the first to develop this idea, and Miss Janet Thornton's report on her work there is very interesting and instructive.\* To those hospital superintendents who object to placing the social worker in the admission office I would suggest that they make use of the studies of family budgets and cost of living, as they have been studied by social workers who are working with these economic family problems.

There are, I believe, two strategic points at which the social point of view is important in hospital administration. These are on admission and on the discharge of patients. It is at these two points that the hospital is making its most vital contact with the community. A thoughtful consideration of the stream of patients asking for admission helps the hospital to interpret the community's needs, and if we are to safeguard carefully the work the hospital has done, we ought to know something of the conditions to which the patient is to return.

One of the common requests that comes to the social service department is that of freeing the wards of chronic cases. In a survey we made a few years ago, almost all the departments reported that this was one of the special duties the administration had placed upon them. If freeing the wards of chronic cases is going to make it possible to admit other patients, it certainly is a proper thing for us to do. But there is one plea that I wish

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\*"Social Service and Dispensary Admission Service," THE MODERN HOSPITAL, April, 1919.

to make, and that is that the discharge of patients should not always be construed to be an emergency. This will have a familiar sound to hospital social workers. At two o'clock in the afternoon we have word that a patient must be gotten out that afternoon, or at least by the next morning. He lives in a lodging house twenty-five miles from the hospital, so that the routine discharge cannot care for him. The visiting physician has made rounds and suddenly discovered that the patient is ready to go out. They may want to take in some new and interesting cases for clinical teaching. But we social workers cannot always do good social work on the emergency basis. And I question whether a discharge need ever be an emergency. How can we anticipate discharge more definitely? Discharge means to us not merely the transportation of that patient to his home, but rather the application of our principles of social case work, which are to secure our facts before we act, and to make a plan with the patient, a far-sighted plan, and not just a temporary, makeshift one. The question of proper discharge of patients is certainly a thing for us to help with, but if we are to help adequately, we ought to get at it earlier than just at the point of discharge.

THE CHAIR: I have asked Dr. Winford Smith, Director of Johns Hopkins Hospital, to open the discussion of Miss Cannon's paper.

DR. SMITH: I have nothing to contribute by way of discussion to Miss Cannon's presentation of the subject of the social service worker in our various hospitals. Indeed, I should feel somewhat presumptuous to attempt to define in any way the function of the social service worker after it has been presented by one whom we all have come to look upon as an authority and a leader in all work pertaining to social service—Miss Cannon. I can only comment briefly upon a few of the points which she has made, not with the idea of adding anything except possibly support to the views which she has already expressed. As I sat here this morning, I could not help but look back and think what an astonishing growth the social service movement has had. If we stop to realize, it is only a few years since the time when social service work in our hospitals was just beginning. I remember my own first experience in connection with a social service department. It was, I think, eleven or twelve years ago, only, soon after I had gone to Bellevue Hospital, New York, and the incident made a profound impression upon me

and, I think, started me to thinking properly with an appreciation of the value of the social service worker. Briefly, the case was this: a patient came to the outpatient department and received treatment through several visits. It was not considered that anything very serious was the matter with him. Suddenly, on the examination table under examination, he died. The doctor was very much upset because of the peculiar relationship with the then existing coroner's system in New York City and Bellevue Hospital, and he came to me to know what to do. Possibly it was because I was somewhat in doubt and did not know any better, that I decided to refer one phase of the case to the social service worker. Now, ordinarily the notice would have gone to that man's family, "Your husband has died. Kindly call at the hospital and make arrangements for the removal of the body." It was a realization that that family, that man's wife and other members of his family, had no right to expect any such word, and a realization that the shock would be very great. The case was turned over to the social service worker, that particular phase of it, and this was what was found: The wife was ill, ought to have been in the hospital. There were four children at home; two of the children were ill; on the occasion of the visit of the social worker a child of about ten years was attempting to prepare a meal from very meager materials, with which to feed the other members of the family. The wife was, as I say, ill, mentally and physically, because the week previous one of the children, in playing with matches, had been burned to death. The family was practically destitute. The long and short of it was that the mere accident, or however it may have happened, of referring that case to the social worker, established a very definite connection with the family and with the proper relief giving agency of that community. The growth of the social service movement in all our hospitals, particularly the larger hospitals, has been so rapid that it has been very difficult for us to see where we were to stop. I think, if I understand correctly, Miss Cannon's department in Boston has been financed very largely by funds outside of hospital funds. If I am not correct, she will correct me. Most of us are obliged to consider the financing of a large department of this kind from hospital funds and we are faced with the responsibility, the necessity of persuading those who are responsible for trust funds that this is a legitimate expenditure. I can remember so well shortly after



I went to the Johns Hopkins Hospital nine years ago, at which time we had one social worker, I attempted to present to the finance committee of the trustees the need of additional social workers, and in my inexperienced, halting way, attempted to explain to them that it increased the efficiency of the hospital. This was one point I made, that it would enable us to get patients out of the wards quicker by providing a proper place for them to go, and get other patients in that were waiting for beds. One very hard-headed business man on the board said, "But what do you save there? You are simply extending the treatment, you are filling up the beds, you are merely adding one other expense." Well, I said, "That increases the efficiency of the hospital; in other words, we are making a bed do more work than it was possible to make it do before in serving a larger number of our people." To which he replied, "Yes, but it is very difficult to prove that by any system of bookkeeping." And it is difficult in some ways; but if one keeps at it and answers the various questions of that sort that are presented, one will be forced to educate himself to a certain extent, to a proper appreciation of what the possibilities really are. In this audience no argument would be necessary to sustain that point, that by making the turnover more rapid and increasing the use of the beds, the hospital was really increasing its efficiency. I was very much interested in Miss Cannon's reference to the human relationship; that it was rather a pity that the doctor had found it necessary to delegate certain of his work to the social worker; in other words, that he had suffered somewhat in his loss of the close human relationship. A pity it may be, but certainly in our larger clinics, indeed in most of our hospitals, where the tendency is to become more or less routinized, there is a necessity of establishing this sort of a department which does supply that human touch, that human relationship, which, in my opinion, is one of the very great functions of the social service department. In our busy out-patient departments and our busy admitting departments for the indoor service, without the aid of the social worker I am very much convinced that our hospitals would now suffer very much in the lack of human relationship and in appreciation of the human problem. If we stopped to think for a moment, before we had the social service worker, we were admitting patients, ascertaining on admission that they had a pain and where it was, then admitting them and proceeding

to cut it out or remove it in some other way, and then discharging the patient with little or no knowledge as to what condition that patient was to return to, whether the conditions were at all suitable for a discharge from the hospital or not; our responsibility was ended. It was just as shortsighted a policy—and it is astonishing that we let it go on so long—it was just as shortsighted a policy as the policy which I mentioned the other day, which I think is urgent in its demand for attention, of our discharge of patients from hospitals every day, everywhere, with no machinery in the community to take the physically handicapped and make the work that the hospital has done, complete and thoroughly efficient. We have now, I think—I am never quite sure from day to day—12 or 13 social workers in our hospital. I am sure we could use twice that number to advantage. Those are salaried social workers. In our pediatric department, in our psychiatric department, in our tuberculosis department and in a department known as department L, which really deals with the problem of syphilis, all cases suffering from that disease being referred to the one department, I am sure that I interpret correctly the attitude of the chiefs of those departments when I say that it would be impossible to do effective work without the presence of the trained social workers in those departments. The same applies possibly in a lesser degree to the other departments, but in those particularly I have had repeated assurances of the importance of the work, the actual necessity of workers and constant requests for more workers. We have no social worker at the admission desk; it is possible we may come to it. A physician presides at the admission desk, one of the administrative officers. A considerable number of cases are, however, referred to the social service department for investigation and report. I was interested to note that Miss Cannon put special emphasis upon the importance of the discharge of the patient and referred particularly to the function of the social service worker in connection with those patients applying for admission, who, for one reason or another, are refused admission. It is a very simple matter to say "I am sorry, but we have no bed, you will have to apply somewhere else." I believe that that is a very distinct function of the social service worker; I believe that if the hospital is really attempting to function efficiently as in public service to the community, it is our duty to advise those patients who come to our hospital in the very best

possible manner, not only that they require hospital treatment, but if we cannot take them, with our better knowledge of what the facilities are in the city through the contact of the social worker, it is time saving and oftentimes a saving of much suffering, needless suffering, if the social service department can take that patient, get in touch with the various other hospitals appropriate for his treatment, and stay with him until the proper disposition is made. In my opinion that is a very distinct function of the social service department and does enable the hospital more completely to function in its proper relationship to public health service in that community. The administrative function of the department clinics is a very pertinent question. In our large, busy outpatient departments, and it is particularly true if they are teaching departments to a very considerable extent, it is a very simple matter, once you get a trained social worker in the department, for a great deal of the management of that particular clinic to be turned over to the social service worker. I am not completely educated on the subject, although Miss Brogden, the head of our social service department, is trying her best, but I can see that there is a waste of specialized ability in occupying the time of a trained worker with the merely routine management of the clinic, and merely to express an opinion, it seems to me quite logical that in some way we should, instead of attempting to provide more trained workers, one or more of whom will put in a certain amount of time in the routine management of the clinics, we shall provide clinic clerks or managers—I do not like the term, but it is used and I refer to it in that way—who will manage the routine of the clinic in order to conserve the time of the physician and the time of the trained social worker. It has been a great pleasure to me to listen to Miss Cannon's presentation of the subject. There are many phases of social work which I am quite sure we have not yet touched upon. I am a strong believer in the value of the social service department of the hospital.

THE CHAIR: I will ask Dr. Bachmeyer, of the Cincinnati General Hospital, to continue the discussion of Miss Cannon's paper.

DR. BACHMEYER: I feel entirely incompetent to continue the discussion after two such authorities as have spoken. I can only, with your permission, refer to our own experience. Our department of social service is not well organized today, largely because of the financial

difficulties that we have tried to meet. The City and Municipal institutions, as we are, has been manned by hard headed fellows who want to know just what social service was and what value in money it meant to the city. It began in 1910 by an outside organization, hospital social service organization. Later on we did induce the city to take over some of the workers, and now, within the last six or eight months, because of bankruptcy, practically, the city has again said, "You will have to do away with some of these workers." I have said to them "The time has come when we cannot do without our social service department; it is just as vital a department in my hospital as the operating room, as the admission desk itself, as the information bureau. I must have it."

THE CHAIR: The subject of the next paper is "Treatment and Care of Patients in the Grey Nuns Institutions," by Sister St. Gabriel, Montreal, Que.

SISTER SAINT GABRIEL: The movement produced during the last few years in view of concentrating the energies of women in hospital work is becoming more and more wide-spread; and never more than at the present moment do we appear to understand what a degree of intensity we might attain by uniting our forces. Experience proves what the science of the twentieth century would gain by concerted action.

It is the fellowship of nations that has won the palm. Fellowship, with the science of our doctors and the devotedness of our nurses, religious and secular, would renew in a great measure and in point of view, physical and moral, our society enervated by so many false principles. True fraternity comes from Christ. The actual events show that charity will be the more active if it be really true charity, that is, if its motive be supernatural. As religious people devoted to the professional service of the sick, we should bring the influence of our good will to every generous undertaking.

Today the leaders of America's medical profession honor Montreal with a convention. The information that has been sought and the experimental ideas that have been collected on all sides will help to alleviate the innumerable evils of poor suffering humanity.

If in our day, we speak so much of the need of social work despite the presence of so many different organizations, and if we deplore at the same time the alarming progress of evil, is it not a proof that something is lacking? Too often, indeed, there is a want of unity of action,

of sound doctrine, and solid foundation for the virtues on which rests devotedness. Philanthropy must come back to Christianity which will make her recognize the truth under the humble garb of charity that does not shrink from sacrifice.

The more place we give to morality in the science of treating the body, the greater shall be the service rendered to humanity, in dispelling what should alarm every right thinking mind. Morality better understood especially where the influence of women is most necessary, would create astonishing results for the preservation of the race, in spite of all physical and moral decadence. "Be worthy of thyself, then only wilt thou be strong." This is the key note of social order.

We are all the more eager as regards those serious questions that disturb so powerfully and so lawfully the minds of today if we acknowledge that the Gospel alone has inspired them. The more we harmonize our views with genuine principles and disengage ourselves from all selfish interests, the more clearly will the needs of our country appear for the greater glory of God and the future of the nation. Our institute is due to the courage of our Venerable Foundress, Mother d'Youville, a courage which inspired her to relieve the many forms of human suffering. From the beginning we see her receiving, without distinction of race, the afflicted—at first those wounded by the Indians, whether Iroquois or Hurons. Hence comes the name that has prevailed and that still designates our mother house—General Hospital of the Grey Nuns of Montreal. This tree newly planted beneath the shade of the Cross, December 31, 1737, was so deeply imbued with the vigor of life, that from its fertile trunk sprang other trees of equal divine strength—the Grey Nuns of St. Hyacinth in 1840, the Grey Nuns of the Cross of Ottawa in 1845, and the Sisters of Charity of Quebec in 1849. Sheltering all kinds of misfortunes, it covers the greater part of North America with its numerous branches.

From the first years of its existence, the community was occupied in social work; the sick were cared for in their homes and in the wards of the hospital. The Grey Nuns were also happy to devote themselves in the different epidemics that have decimated our population. During the typhus fever in 1847, the cholera in 1849, the small pox in 1885, and at a more recent date, the Spanish

Influenza in 1918, they were employed in the municipal hospitals and elsewhere as nurses.

The care of abandoned children or foundlings was inaugurated on November 16, 1754, by our Venerable Mother and since, at the cost of many sacrifices, has been continued uninterruptedly. Today, in our mother house, we have a regular baby hospital with an average of 130 to 160 infants. The attending physician is a specialist for children from the Montreal University with the right to hold clinics. The children are cared for by the sisters and nurses who follow regular courses that qualify them after a theoretical and practical examination to obtain a diploma in pediatrics and puericulture.

The course of Domestic Science given at St. Joseph's Asylum of Montreal, as also in the industrial school at the mother house and in a minor measure in all our orphanages, furnishes sufficient knowledge for urgent cases. On several occasions, our young girls have been able to give treatment and follow up the symptoms and the progress of a period of sickness.

To be prepared for the different works of our institute, our young sisters during their probation, follow a preparatory course of nursing.

The most important work of charity in our community is incontestably the care of the poor and the sick in their homes. The Sister of Charity as the nurse, consoles and cares for the poor whom she visits and who are, more or less, very sick patients. These public acts of social service may be summed up annually as follows: Prescriptions filled, 18,181; dressings, 125,262; visits to the poor and sick in their homes, 38,692. These figures do not include what is done in our hospitals.

The mother house has at different periods opened fifteen hospitals. As to the care of the sick in regular hospitals, we began in 1855 in Toledo, Ohio, then only nineteen years in existence and with a population not exceeding a thousand souls, St. Vincent's Hospital which now has, and has had for several years, a very large training school for nurses. Dr. Smith of the American College of Surgeons, gave the following testimony in favor of St. Vincent's Hospital: "St. Vincent's has met all the requirements and has come up to the standard in every way." In 1894, Holy Ghost Hospital for Incurables of all creeds and nationalities was established; and in 1906, St. Joseph's Hospital, Nashua, N. H., a modern general hospital. In 1907, St. Peter's General Hospital, New Bruns-



wick, N. J., was registered in the state of New York and affiliated with the Memorial Brady Hospital at Albany, N. Y. From the reports of the four hospitals owned by the county, the representatives of Middlesex acknowledged that our institute received the greater number of poor patients.

In Western Canada, our sisters were considered as nurses on their arrival in 1844, seventy-six years ago. It was in 1871 that the regular hospital of St. Boniface, Man., was opened, a humble modest foundation exposed to all the rude privations of establishments among the Indians.

The apostolic zeal of the bishops and of the Reverend Oblate Fathers and their devotedness to civilization have converted these institutions into so many centers of progress in such a way that, after only a few years, we find hospital houses where all the advantages of modern science are combined in a truly astonishing manner. St. Boniface Hospital, Man., measures 428 feet long and can receive 500 patients. It is considered one of the best and largest of Western Canada. Since 1914 the Minister of Militia confided to our sisters the care of a large number of soldiers. At the present date, 8,500 have been registered.

St. Rock's Hospital, in 1885, was planted by Divine Providence on the ruins of an old ice-house belonging to St. Boniface Hospital, in order to isolate the patients suffering from contagious diseases. Several modifications and enlargements made from time to time (until 1904) have given us the present hospital. In 1891, Holy Cross Hospital, Calgary, Alberta, began as a tiny building, twenty feet square, has progressively grown till it has become a modern general hospital, capable of receiving 200 patients. In 1894 the Edmonton General Hospital, Edmonton, Alberta; and in 1907 St. Paul's Hospital, Saskatoon, Sask., were opened. The latter on the occasion of an epidemic of typhoid fever. The same year saw the beginning of the Regina Hospital.

Our hospitals in the United States and in the Northwest, with the exception of the Incurables (Cambridge, Mass.), are general hospitals, following all the modern improvements and capable of receiving from 100 to 200 patients. They all have committees or staffs of physicians, surgeons, and specialists, as also intern doctors for the immediate care of the sick. In the United States several of these members belong to the American College of

Surgeons, to the Catholic Hospital Association, and to the American Medical Association. One thousand one hundred and fifty-two nurses have graduated from our hospitals in western Canada and in the United States; the greater number of these employed in regular service have been registered. Two of our sisters have obtained the university diploma for pharmacy with distinction, two others for laboratory work, and a third is studying for the same grade.

The recruiting of nurses is becoming very difficult and will probably soon be a problem; consequently, the hospitals of the two territories have been unanimous in requesting the liberty of receiving young girls from the eighth to the ninth grades. If endowed with practical judgment and a good heart, these young girls would faithfully fulfill their part as bed-side nurses. That the élite, the minority, aspire to the university grades is very praise worthy; but practically it is the majority who are destined for the simple formation of nurses for the more urgent cases. To exact a higher degree of instruction from the candidates would close the profession to excellent nurses and would deprive us all of precious and even necessary auxiliaries.

In the province of Quebec, the community has St. John's Hospital, opened in 1868. Situated on the border line, this hospital is remarkable for its numerous cases of surgery.

The Sanatorium of St. Agathe was founded in 1914 for tuberculosis patients. The Ophthalmic Institute in Montreal was opened in 1892. Notwithstanding the small space it occupies, this hospital has a great number of specialists at its service. Its dispensaries relieve many poor patients.

Notre Dame Hospital, founded in 1880, owes its existence to the generosity of the Sulpician Fathers. It was especially established as an emergency hospital for the many accidents at the harbor. A hospital of fifty beds at the outset, it now has a capacity of 150 patients. The general service is acknowledged and highly praised for its scientific attainments. Its dispensaries make up for its want of space. Last year, its different services treated 4,398 patients; 13,781 consultations were given, and the dispensaries filled 14,693 prescriptions that were served from the pharmacy. Its annex, St. Paul's Hospital, opened in 1905 for contagious diseases—in particular diphtheria, scarlet fever, measles, and erysipelas—has 121

beds. Notre Dame Hospital's training school for nurses, opened in 1899, has sent out 165 graduates. Our nurses have just obtained from the Province of Quebec their registration with affiliation to the principal medical centers, thus assuring them of the prestige of a legally authorized capacity.

After having our works of charity in the United States, in the Northwest, and in the Province of Quebec, we are happy indeed to see them flourishing in the frozen countries of the extreme North, in our last established Province, in the McKenzie River District, N. W. T., which comprises five houses. Besides the general works of charity absolutely necessary among Indians, they are real hospitals, as appears from the following statistics. Sacred Heart Convent, on the McKenzie River, founded in 1867, during last year cared for 182 patients; Holy Angels' Convent at Lake Athabasca, opened in 1874, in the same space of time treated 195 patients; St. Joseph's Convent at Fort Resolution, Great Slave Lake, cared for eighty-five patients. The last two foundations are regular hospitals. The General Hospital, at Fort Smith, on Slave River, opened in 1914, has a capacity of twenty-five patients. St. Margaret's Hospital, Fort Simpson, on McKenzie River, opened in 1916, has a capacity of 30 beds.

These hospitals, notwithstanding the difficulty of communications, have not only what is necessary, but relatively are very comfortably established.

MR. RICHARD BORDEN: I do not intend to discuss the paper which has just been read, although there are many things which are worthy of inquiry and which are suggestive, but I am constrained to suggest that there is this morning a very pleasant episode which should be noted; the theme for discussion today has been social service and the first speaker represented, as a leader, the new thought, the new methods which have been adopted for the service of the suffering world. On the same platform, in the ancient and honored garb of her order, Sister St. Gabriel described the results of long and continued years of social service, a kind of service on which, after all, practically all our social activities are based. This episode comes in the city of Montreal, where work of this kind has long been established and carried on in Canada, where we, from the United States meet on the common field of social service. The two episodes of the old regime in social service and the new, of the two great nations joining together to consider the same subject, seems to be a prom-

ise of great power, great usefulness, and great progress in social service as conducted and as fostered by this Association in the years to come.

THE CHAIR: The next paper on the program is "The Report of the Social Service Survey Committee," by Mr. Michael Davis, Jr.

MR. MICHAEL DAVIS: Mr. Chairman, ladies and gentlemen: I have to present a report for the committee of the American Hospital Association appointed by the President of the Association immediately after the conference of last year, as directed by the Association. As was announced by the Executive Secretary at the opening meeting, the expenses of the Committee, including its meetings and the expenses of its Field Secretary and General Secretary, have been met by the gifts of an interested individual, who does not wish at this time to have his name mentioned. The committee, I might mention, includes sixteen persons. Without reading their names, I may say that it includes a number of the hospital social workers themselves, such as Miss Cannon: it includes representatives of the nursing profession, of the medical profession and the hospital superintendents. The two great problems before the committee were the definition, if a definition can be framed, of the duties and functions of the hospital, of the dispensary, of social service and the working up of something which will help in the training and education of workers for this field. There is obviously a great need for an additional number of properly trained workers. There is also an evident demand from workers now in the field for additional training, because the field has called people before there has been opportunity for adequate training. Dr. Anna M. Richardson has been the Field Secretary of the Committee and the other members of the committee feel themselves most fortunate in having had her help. She has been all over the country, to California and to many places in between. Some three hundred social service departments exist in the United States at the present time and of these, sixty have been studied by Dr. Richardson. These sixty departments, although only 20% of the total number of departments, include over 40% of all the salaried social workers in the hospitals of the country. No attempt has been made therefore to cover every social service department. The effort of the committee has been to cover the things or work or departments that were representative of the various hospitals and dispensaries, the teaching and non-

teaching, small and large, western and eastern hospitals, associated with the Church or the municipality, and the privately supported institutions.

The committee at the present moment has not prepared its final report. It was the intention that this committee should present its report one year from the last Convention, that is now, and then let such action be taken upon it as possible. The committee is prepared at the present moment to present a tentative report which it hopes will be acted upon by the Trustees in the near future, when a final report can be presented. It was the sense of the committee that the result of the meetings at this convention and the discussions that would take place here in the committee as well as in the whole meeting, would doubtless give suggestions and opinions which would be of value to the committee in shaping its final report of operations. I will therefore speak briefly and tentatively of the conclusions we have reached.

It will be of interest to many here to know that in the sixty departments there were 350 paid workers. Those workers have given us a fairly full statement of themselves, what they were doing, what they thought about their work, what their previous training had been. We have these records of what the people on the job think about the job, its needs and its future and their own part in it, and that material has been and will be one of the very valuable foundations for any conclusions we may come to. It is interesting in view of the many discussions that have taken place at these sessions in past years, to note that of the 350 workers, 55%, or a little more than half, have had a nurses' training and 45% have not had a nurses' training. Furthermore, we found that a minority, that is, about 25% of the departments, were employing only nurses, that a small number were employing both nurses and non-nurses, that is, were mixed groups and a few were employing no nurses. It is furthermore very interesting to see that the head workers of the departments, the responsible heads, while in 35 of the 60 cases, they were nurses, in a considerable number of instances we found nurses as heads of departments who were employing non-nurses as well as nurses. We could trace no connection, practically, between the fact as to whether or not the head of the department was or was not a nurse and whether the department included nurses or non-nurses. Departments headed by nurses in some instances have almost their entire personnel non-nursing workers,

and departments headed by non-nurses have many of their workers in some cases who are nurses; in other words, it would appear that the actual present practice of social service departments as represented by these larger and more representative ones, lead to the conclusion that the people in the field directing this work in the main do not consider that the presence or absence of a nurses' training is a determining consideration in the engagement or retention of a worker. It is obviously one of the considerations, but does not appear to be regarded as a determining one.

The most important point to which the committee needs to address itself is, what, after all, is social service in a hospital or dispensary? Dr. Richardson has drawn from the actual observation of the work and conferences with superintendents and doctors and social workers and others, a list of the various activities which she found carried on in these 60 departments. I think her list includes more than 70 different activities. There are evidently more varieties of hospital social service than people ever dreamed of. The varieties include such activities as filing records at one extreme, intimate personal case work with the physician at the other, administrative activity and personal activities of all kinds. In the face of such a mixture of activities, what is the key one? What is the significant one? I think I may say that it has become clear to our committee that there is at the present time, a considerable lack of clear understanding in the minds of many of those who are practicing or supporting hospital social service as to what the real essence of the job is. This mixture of activities which often takes place within a single department, can only go on if there is a lack of such definition in the minds of those who are really concerned with hospital social service. We have come to the conclusion that the essential feature is special service in the dispensary in its relation to the medical care of patients. Hospital social service goes into the hospital and is there for the same reason that the hospital exists at all.

The hospital exists for the purpose of giving medical care; social service exists as an adjunct to the essential purpose of the hospital, the medical care of the patient. If that fundamental point is clearly and definitely understood, the other activities follow from it, for I think that no one will be more ready than the administrator of the hospital to agree that the administration of the hospital



is there for the purpose of making the medical care of the patient effective. It is perfectly natural and obvious as was said several times this morning in the earlier discussions, that social service may take a part in the administrative work of a hospital or dispensary, but it must do so just for the same reason that the hospital or dispensary exists at all, namely, to make the medical care of the patient more effective. That basis of hospital social service, if clearly understood and worked out, will lead to a better relationship between these various and sometimes diverse or divergent activities that we find at the present moment.

We do not feel that any social service department or hospital can be regarded as having a social service department if it employs social workers who are concerned merely with administrative activities and do not deal with the problem of assisting in the medical care of the patient by revealing the social cause or conditions of disease and assisting the physician in making treatment more effective. Unless this is included in the activities of the department, we feel that it should not be called a social service department. On the other hand, it is also the sense of the committee that a hospital is not wholly fulfilling its responsibility to the public and a social service is not a complete social service department unless it is assisting in those phases of the hospital administration in which social service can properly be helpful. The education of the hospital social worker will be the subject of a special report by the committee and made a part of its general report, which we hope will be ready in the very near future. I only at this moment wish to say one or two things regarding the educational side. There are two needs that must be met as soon as they can be met; the need of assisting the workers already in the field, engaged with members of the social service department to secure supplementary additional training while in their jobs so that their service and the service of their hospital can be further improved. The second is the task of working out a more satisfactory curriculum subject matter which should be included in the training of the future hospital social workers and of deciding how that can best be adapted to fit the various types of workers who come to this field from the nursing profession, the profession of teaching or social work or from colleges directly; how the curriculum shall be adapted to these various groups.

Our committee has divided itself into sub-committees

for the purpose of dealing with various and special problems and to assist in the prompt rendering of its final report. The group of superintendents represented here, and others in the Association, will perhaps be most interested in the conclusions of the committee as to the organization of social service in the hospital or dispensary. There have been many social service departments which have been started through the interests of an individual or a committee or some body or group from without the hospital itself. Our committee does not fail to recognize that reasons of practical convenience or of finance or of the close connection of an individual with the social service movement in a city, may lead to the formation of a social service department under the auspices of some individual or group not officially part of the hospital; yet we feel that it is a fundamental and necessary principle that a social service department should be organized and directed as part of the hospital organization under the direction of its administrative officer as are any other departments of the hospital itself; and whereas we recognize temporary conditions which may lead to the starting of the department under our auspices, we believe that at the earliest possible moment, the satisfactory organization should be brought about of having the social service department an integral part of the hospital organization.

We think it is wise that particularly during the formative period of social service through which we are passing, there should be in an institution an advisory committee on hospital social service including such representatives as members of the Board of Trustees, of the Medical Staff, of persons who have an interest in social service in the community as a whole, and the superintendent of course, as a member, the head worker of the department as an ex-officio member, meeting with the committee, such an advisory committee to be an aid to the Trustees and to the superintendent of the hospital in working out the policy and methods of the department particularly during this formative period. The parallel with the problem of the nurse in the hospital and the nurses training school will occur to everyone. Advisory committees create problems sometimes as our committee recognizes and yet, on the whole, we believe that an advisory committee on social service is desirable as a general recommendation.

In the matter of finances, which is never far absent from the mind of the hospital administrator, at the present time our committee feels that, just as it is important

for the social service department to be part of a hospital organization, so it is necessary that social service shall be financed as part of the hospital budget. That carries with it the usual accounting for the department in the hospital's report, the accounting for the department in the terms of its main breadth of activities such as the separation of its activities in the hospital and dispensary, that these may be accounted for financially. I realize that social service brings a financial obligation upon the hospital, sometimes a heavy one; at the same time I would add that social service is likely to bring to a hospital new sources of support, new elements of interest from a community. A social service department added unto a hospital may, and usually should, enable the hospital to reach individuals and groups who have not previously been interested in the activities of the institution. Social service brings elements of an appeal which, if properly made use of, in my experience would add to the hospital's circle of friends and supporters sufficient to maintain the social service department and to strengthen the position of the hospital in the community as a whole.

The financing of the social service department by special funds or by special committees, raises at once, problems of organization. We feel that the principle of centralizing the authority for all departments of the hospital in the hands of the Trustees or the Superintendent is an essential principle and must be applied to the social service department, and its logical indication means the assumption of the financial responsibility for the department. Our committee hope to have its final report including its recommendations, some of which I have briefly rehearsed to you, ready within a month from this time. Its report will also include recommendations on the educational side, on which I have only very briefly touched just now, and will include a detailed report from Dr. Richardson as the Field Secretary, telling of her trips throughout the country, explaining the places she has visited, the activities she has found, the different types of organization, and the facts upon which the committee's conclusions are based. Some of those detailed facts will, I think, be presented this afternoon at the sectional meeting where Dr. Richardson will speak. Our committee wishes to ask that this tentative report be received by the Association and we hope it will be referred to the Trustees with such power to act that the Trustees may be enabled to take action on the report when it is submitted to them in the

near future. Our committee has felt that the responsibility devolved upon it from the Association of investigating a new and yet undefined field of hospital service.

It has been the prime duty of the committee to see how this new branch of work of the hospitals would fit, on the one side, into the long established hospital organization, and on the other into the organization of the community, and as all those who have given any attention to social service in the hospital recognize, the problem is not an easy one. Hospital organizations are none too flexible and adapt themselves with no great readiness to new elements. The organization of a community likewise only with difficulty adapts itself to a new function introduced within it, such as this medical or hospital social service. The committee hopes that as a result of its report, there may be a clearer understanding that the social service goes into a hospital and dispensary for the purpose of improving medical service for the purpose of assisting the physicians and administrators of the hospitals or dispensary to accomplish the primary purpose for which the institution exists at all. If, in some measure the committee's report and studies aid in the accomplishment of that result, we shall feel repaid for our labor.

THE CHAIR: You have heard the report of the committee. What will you do with it?

MR. DANIEL TEST: I move that Mr. Davis' suggestion be accepted, to receive this report and refer it to the incoming Board of Trustees with power.

## AMERICAN HOSPITAL ASSOCIATION

### SECTION ON SOCIAL SERVICE

Montreal, October 7, 1920, 2:00 P. M.

MISS IMOGENE POOLE, of Ann Arbor, Michigan, Chairman, presiding.

THE CHAIRMAN: This section of the American Hospital conference has been meeting for the last several years to discuss the problems concerning the medical social work in hospitals and dispensaries. We have a little sectional business that we must look after, but which we will attend to a little later on in the afternoon, after this meeting. The first paper this afternoon is a treatise on "Medical Social Work as a Therapeutic Factor," by Miss Edna G. Henry, Director of Social Service, Indiana University, Indianapolis, Indiana. Unfortunately Miss Henry is ill

at her home, and she has sent her paper on, and it will now be read by Dr. Anna Richardson.

DR. RICHARDSON: Unless medical social service has a therapeutic value it does not belong in hospitals and dispensaries, for the primary business of a medical institution is the cure of or care of patients. It can waste no time nor money upon any other activity.

It is often pointed out that hospitals are coming to feel a new responsibility toward their communities, and that a social service department help them to meet this new felt obligation. It may be true that the hospital has a new conscience about justifying its existence to the community which pays for it. It is certain that it has an opportunity to spread the gospel of health and to maintain a link between the sick within its walls and the city without, which will prevent the making of much human wreckage. However, it is not a fact that the hospital has any true duty except that of curing and caring for the sick who enter its doors. This work must be done more efficiently and completely than in the past; but the doing of it constitutes the hospital's whole task.

Recently a doctor was heard to say that the engineer who kept the hospital well heated did more for the patient than a social worker. It could well be argued that the dishwashers and janitors helped to further the cure of patients. It is perhaps upon this theory that so-called social workers are being asked to do trivial administrative jobs which are in no way therapeutic and merely add to the comfort and efficiency of the institution. A member of a social service department, in order to further her own ends or through a willingness to be generally helpful, may make financial investigations for the hospital, keep account of expenditures for braces, the regular return of patients for reexamination, and do clerking at the admission window. But this is not social work and should not be done by a well trained and highly paid social worker, unless the doing of it gives her a better opportunity to touch her own problems earlier, and more effectively.

The medical institution can have no use for a laboratory man, an x-ray expert, or a social worker who does not know his own job and contribute something which the other members of the staff cannot give.

### Definite Problems of the Social Worker

But what is the business of the social worker? The one definite problem always before her is "the study of character under adversity and of the influences that mold



it for good or ill. The specific business of the medical social worker is the study of character under the adversity of illness. The social worker's task, therefore, is a more generalized one than that of the physician. Like him, she must concern herself with the whole man, his environment, his physical condition, and his mental or spiritual make-up. Working with and for the physician in a medical institution, to further his purposes, she must study these three aspects of the patient's life in order to contribute from her knowledge of them to the physician's need for facts which are not obtainable often by the physician himself except in private practice.

The outline for the proper activity of a medical social worker, or indeed any social worker, should be precisely that followed by the modern physician—relief of symptoms, diagnosis, prognosis, treatment, and teaching for prevention.

She should first give her attention to the relief of symptoms. If these symptoms are those of physical suffering she must secure and cement a link between the patient and his doctor. If in doing this she discovers symptoms of economic or spiritual distress, she must give her attention equally to them, either at the request of the physician or of the patient.

### Must Have Cooperation of Doctor

Having done all that is possible to relieve symptoms, she must make a social diagnosis. An accurate social diagnosis cannot be made without an accurate medical diagnosis. It would be impossible to secure proper employment for a patient with myocarditis without first knowing that he had myocarditis. A man whose physician has not yet determined whether he has lead poisoning or anemia should not be returned to his old paint shop.

With a good doctor, after diagnosis comes prognosis. Even should he decide that nothing of ultimate good can be given his patient, he will do all that he can to prevent and to relieve suffering; but he will not advise needless operations, expensive treatment, and worrisome care. Most good social workers have now accepted the necessity for the relief of symptoms and a diagnosis; but very few are yet wise and brave enough to demand a prognosis also and to act upon it. This is as essential in social work as in medicine, and if not sought, will work much harm and rob many of needed assistance.

Prognosis once made, treatment follows. The physi-



cian will attend to the medical treatment. The social worker must beware and in no instance give or permit to be given advice which is either not in accord with that of the doctor in charge or not distinctly directed by him. Neither can she safely proceed upon general hygienic knowledge, diet lists, or miscellaneous information. To be of real service in the medical care of a patient, she must have doctor's orders.

A social worker once visited a discharged baby whose mother's sister had been an old chorea case in the hospital. Upon her return she insisted that she must have more medical knowledge. Her head worker had difficulty in persuading her that it was not medical knowledge she needed. "But I slipped up," she protested. "Yes," said the head worker, "you did. But you cannot be a doctor and a social worker both. What you should have done was to have said to the doctor that you were going to visit Helen's home and that you would like to know what information he needed or what instructions you should give Helen."

### Prevention Must Be Taught

While most social workers stop at diagnosis, most physicians stop with treatment. Both should go on to teaching for prevention. This does not mean only the training of other social workers, medical social workers, medical students, and student nurses; it means the definite education of patients and educative pressure upon the community out of which they come. The medical social worker, without going outside of her own field, is better able than anyone else to collect cases illustrative of the large problems. It is she who will first discover the industry which is causing occupational disease or furthering immorality. It is she who will first note the neglected trachoma cases and find the neighborhood where all the babies are "measured" instead of fed.

No matter, however, how good the social worker is nor how needed social work may be in any community, no medical institution which does not give a high type of medical service should waste time or money upon the maintenance of social work. And no institution will make a proper use of such a social worker unless there are upon its staff physicians who understand how a social worker may be used to further their own purposes. It is the physician's business to see that his patient gets well. It is the social worker's business to bring to his

aid all of her social and community knowledge, and at the same time to ask herself what other essentials are missing in the patient's life. To the physician health is all-important. To the social worker, health is of importance only as a means to an end. Without health the patient can be of no use to his family or to his town. With it he may still be worthless. In order to act justly and efficiently, the social worker must understand the physical condition of the patient and be prepared to help the doctor carry out any plan for him. But in order to do this she must know more of the patient than his physical condition.

Several years ago a patient was referred to a department for a change of employment, without which he could not improve. This patient had lead poisoning, incipient tuberculosis, and only one leg. Upon investigation he proved also to have a blind wife, poverty, and all sorts of domestic sorrows. The possibility of carrying out the doctor's desire for him seemed most remote. After various vain efforts, the social worker one day said to the patient, "Mr. Brown, it certainly is serious to have lead poisoning, tuberculosis and one leg, but I think that there is something else more serious still, and that is a melted back bone." Mr. Brown laughed, and tried the job she offered him, thus at last solving his own problem.

### Doctors Need Social Workers

There are certain types of physical conditions which always require social work in addition to surgical and medical care. Social aid may be given by the physician himself, by the patient's family, or by a professional social worker. No baby born in a hospital is entirely safe without after-care. Few cardiacs will be discharged from a hospital never to return without social supervision. All children, all cripples, all patients who are feeble-minded, insane, or epileptic, and all foreigners need or may need more than can be done for them within a medical institution. Patients with venereal disease, tuberculosis, the homeless, and the negro seldom can solve their own problems. Of such patients and others the social worker is well aware, but her therapeutic value lies not in what she can discover herself, but in the service she can render the physician in charge upon his request.

A woman was sent to a hospital with a tentative diagnosis of chorea. The hospital physician at once questioned this diagnosis, and asked the social worker for information concerning the patient's family. The social

worker was able immediately to report that the patient had had four relatives in that same hospital and other relatives in other institutions. Her father had been a drunkard, her mother a morphine habitue, and two sisters insane. The general family reputation was poor, both morally and physically. The final diagnosis was not chorea, but subnormal mentality and entire want of discipline. Consequently, the patient was discharged with proper instructions concerning her which have greatly helped the social situation of which she is a part.

Another patient was referred by the physician because he was sure that her alleged symptoms were entirely due to an unbalanced mental state. Further information revealed the fact that the illness of the patient dated back to an attack of jealousy for which her husband had given her no cause. The jealousy, in turn, had its root in the fact that the patient had had an illegitimate child before marriage, and, consequently, herself was always suspicious. Sending for the husband to talk with the doctor, the social worker and the patient entirely cleared up this situation and returned her to her home a well and happy woman.

Sometimes the continued poor condition of the patient after discharge is not caused by the patient's own disobedience, but by the fact that a wife thinks the diabetic diet foolish, that a husband cannot understand tuberculosis, or that a grandmother thinks that a sixteen-year-old girl with a bad heart should save her strong mother all of the hard labor about the house. It usually takes a social worker to learn that the baby who was forbidden eggs is getting four a day, or that the little patient who was supposed to be only a feeding case is sleeping with a tuberculous grandmother or taking his sick cat to bed with him every night. It is sometimes as important for the doctor as for the relief agency to know that a charity patient, supposed to be living alone with his wife, is keeping seven boarders and a dog. Fresh air cannot be recommended with kindness unless someone is certain that there are blankets, and special foods are impossible for the small wage earner, the poor cook or the ignorant buyer.

It usually takes a social worker to learn that the patient, whose tentative diagnosis of gastric ulcer was not substantiated, has had his stomach trouble ever since as a motorman he killed a child with his car. Nothing else

would make certain so soon a diagnosis, of gastric neurosis and the patient's cure.

The girl with a heart lesion who is ordered to take two years rest when she has no place to go upon her discharge from the hospital except back to domestic labor must have both plans and financial aid. The structural iron worker with the same difficulty can be cared for by five minutes' talk with his employer over the telephone.

But it will be clear to the casual hearer that none of this work can be done, that no satisfactory records nor research nor teaching material can be furnished, without the cooperation of socially interested and intelligent doctors, and also the active partnership between the physician and the social worker from the time the patient enters the medical institution until he is finally discharged. It becomes evident, therefore, at once, that the achievement of such partnership calls for the highest possible type of educated social worker, one who is wise enough to make and to use her own tools and big enough to be willing at all times to serve in the meanest capacity whenever that serving will enable her to offer results, first to her patient, then to her physician, and last to her community.

THE CHAIRMAN: We are very fortunate in having secured a Montreal social service worker to present our next paper, on "Occupational Therapy and the placing of the Handicapped," by Miss Lilly E. F. Barry, honorary secretary of the Catholic Social Service Guild, of Montreal. I take great pleasure in calling upon Miss Barry.

MISS BARRY: The undeserved honor of addressing this distinguished audience is bestowed on me only as a poor proxy for one of the good sisters "whose right there is none to dispute" as regards priority, both in point of time, and for superior achievement in the field of hospital social service in Montreal. But a sister, when the moment comes to claim the credit for her good works, can never be found. She becomes invisible, like a pure spirit.

The Catholic Social Service Guild, which has been in existence five years, supplies, through a well equipped central bureau and staff of trained workers, the equivalent of a social service department for our Catholic hospitals and homes. The workers are trained by the Loyola School of Sociology and Social Service founded on the initiative of the Guild and now entering on its third year of existence. It is under the direction of Loyola College. The two years course, comprising a

thorough grounding in basic sciences, with field work and visits to institutions, leads to a diploma granted by Montreal University.

An important link between the hospitals and the Guild is supplied by the Loyola Convalescent Home, carried on by the Catholic Women's League. Here the social worker may study a case at close quarters, with a view to placing in favorable environment when the working capacity has been restored. The attending physicians and devoted staff lend their hearty cooperation in this direction.

The employment department of the central bureau of the Guild is one of its most successful features. A monthly report is sent to the government for publication in the *Labour Gazette*. Special attention is paid to the placement of handicapped persons discharged from the various hospitals. Our activities extend to all classes of workers; and this is a distinct advantage, as it brings us in contact with a larger number of employers, many of whom yield to the social worker's plea on behalf of the handicapped man or woman, a trial of whom not infrequently gives results satisfactory to all concerned.

To understand the difficulties that confront us, it is important to keep in mind the numerical proportion of the English-speaking Catholic section to the total population. Our territory is bounded by a line drawn around fourteen points—or parishes—(a fashionable number). Only about 60,000 souls, or 13.3 per cent of the entire population come directly under our influence.

We are but a thin strip compared to the French-speaking section, which extends over eighty odd parishes and represents about two-thirds of the population. A French central bureau, almost the counterpart of ours, facilitates cooperation in social service. We maintain close and harmonious relations with the French element; but, in practice, it is found impossible to bring the work of the two sections up to one uniform standard in all directions, or to secure united action on certain issues which affect the interests of the two divisions in a different way. I do not feel hopeful that this will ever be done; nor, in view of distinctive, deep-rooted racial characteristics, traditions and prejudices, that it is necessary or wise to attempt it. We have, however, the inestimable advantage of unified command under the Archbishop, and of our common faith, which creates an indissoluble bond of sympathy and good-will.

An intimate knowledge of both peoples—derived from long and close personal relations with them—convinces one that if each group receives frank and generous encouragement in an effort to reach its highest level, and, through its leaders, to cooperate in a friendly way with other groups, an ideal community would emerge much sooner from this plan of development than from one based on the principle of the bed of Procrustes—in which the victims were made to fit exactly by having their superfluous length cut off, or by forcible stretching, as the occasion demanded.

As far as problems of employment are concerned, our experience goes to show that race and creed lines tend happily to disappear when the worker is qualified for a job, or if the job appeals to the worker. Except where inability to speak or write the language is a real handicap, or where religious obligations might interfere with regularity of service, the question of race or creed is scarcely ever mentioned.

Occupational therapy has not been introduced into our general hospitals such as Notre Dame Hospital and the Hotel Dieu, nor is it likely to be, because it has not been found necessary or feasible. The number of hospital beds for emergencies in Montreal being—all told—only about 2,000 for a population of 801,000, it is imperative that patients be discharged with the least possible delay. When illness or convalescence promises to be of long duration, the patient is transferred to one of the special hospitals with which Montreal is fortunately well supplied. This change is the more easily made as there is often relationship between the sister hospitals also the director of municipal assistance has power to effect such removals when beds become vacant in the institutions designated by the hospital authorities or the social worker.

It is in these special hospitals such as are conducted by the Grey Nuns and the Sisters of Providence, or the reformatories, including the Catholic Female Jail, under the direction of the Sisters of the Good Shepherd, in the Maternity Hospital of the Sisters of Mercy, and the home conducted by the Little Sisters of the Poor, that the most interesting studies may be made of occupational therapy and preparation of the handicapped for reappearance in the industrial world—failing which, they are rendered self-supporting in the institution, or in their own homes.

The sisters—whose lives are wholly consecrated to the service of the poor and helpless, who are never off duty



nor absent from their post in the way of the secular worker, and who, in addition to the severe training of the novitiate, have long experience in practical work, brought to a high standard by previous generations imbued with the same lofty principles and urged by the same compelling motives of service to others—have an influence as teachers which cannot easily be surpassed by persons lacking their superfine qualifications. Habitually filling every moment of the day with useful occupation, the sisters are naturally ardent advocates as well as edifying exemplars of the value of work as a saving factor in every sense of the word. Therefore, they rejoice in an opportunity to encourage a patient's recovery and spirits by the tonic of light employment. This is offered in such an ingenious variety of interesting forms that a volume would not be sufficient to do justice to a description of such works. Plain sewing and knitting, embroidery, lacemaking, dressmaking, artificial flowers, modeling in wax or clay, typewriting and typesetting, bookbinding, Braille work, basket-weaving, bead work, carpentry, and metal work are taught with such marked success to defectives that the normal individual, viewing the results, is apt to feel a most embarrassing sense of personal inferiority.

When fit for more active employment, patients are trained to do housework, cooking, carpet-weaving, painting, care of furnaces and powerhouse, gardening, care of horses, driving, and other outdoor tasks. In the present acute scarcity of labor, especially of domestic servants, no difficulty is experienced in finding places in private families or business establishments for persons trained in our religious institutions and recommended by the sisters. Therefore it is seldom necessary for the Guild to intervene except where a patient does not happen to fit into any opening on the list kept at the institution.

Our central bureau has more contacts with the large employers of labor and therefore greater facilities for providing the higher remuneration needed by the father of a family.

A sympathetic attitude to these problems on the part of prominent citizens, professional men, members of the Guild, and other public-spirited, philanthropic persons, has greatly encouraged us in the attempt to find employment for the handicapped. Last year the Guild was notified of 1,748 vacancies. One hundred and ninety-eight permanent places and 787 temporary jobs were

secured for our 1,176 applicants. Five hundred and seventy-two calls for help could not be met, though 191 applicants had to be turned away as unsuitable. Of these, the greater number were hopelessly unfit through age, intemperance, or incapacity from lack of training; very few of our applicants are free from handicap of some sort. The normal worker does not require much assistance in finding employment under existing conditions.

Special statistics covering this department of social activity in our hospitals and homes are not available; therefore I can give only a general notion of the amount of work being done and of its value to the community, at the same time extending to all our visitors, on behalf of the sisters, a cordial invitation to visit the institutions I have named, and see for themselves how these problems are met. One gratifying feature, common to them all, is the number of handicapped persons regularly employed by them, who in all probability would not be accepted elsewhere.

In one of our hospitals (the Hotel Dieu) a French ex-soldier, a widower, aged thirty-nine, who lost a leg in the war, looks after the garden. He was formerly an agricultural laborer. The sisters are delighted with his intelligence and thrift. He has succeeded in producing twenty-one kinds of vegetables where only five or six grew before, guarding against failure by a well arranged succession of crops.

Another ex-patient, formerly a chauffeur, disfigured by an abnormal growth in one eye, helps in the kitchen, peels vegetables, and makes himself generally useful. He is a cheerful, devout man who spends much of his leisure in the chapel. A truck elevator in the same institution is in charge of an ex-patient, very heavy and stout, who drags one leg. When not in his car, he busies himself in various ways, making keys, chains, picture frames, or any repairs; in fact is so useful that he is regarded as a household treasure.

The Grey Nuns, who have stretched a chain of fifteen hospitals across Canada and the United States, and who cared for 8,500 returned soldiers in their Guy Street Hospital, have a vast experience in handling every sort of human problem. The unmarried or deserted mother and her child, against whom every door is closed, may freely enter the Foundling Hospital and receive training as a nurse or in domestic work. In their special hospitals for the blind, for deaf mutes, and nervous patients, as in

their splendid orphanages, constructive work of the highest order is done. The finest demonstrations in occupational therapy can be seen in these institutions.

The blind and partially blind are taught to be self-supporting by making brooms, caning chairs, tuning pianos, printing Braille, map-modeling, dressmaking, and tailoring. Deaf and dumb patients excel in needlework, clerical work, typewriting, and other remunerative occupations, seldom becoming a burden to their families or the community.

The Sisters of Providence, founded seventy-five years ago by Madam Gamelin of Montreal, have become especially prominent in social service, their noble aim being to care more particularly for the classes of suffering poor who are refused admission to other homes and hospitals. Their hospital for incurables would alone earn for them the deep gratitude of the city. It is a magnificent demonstration of the highest form of charity. Not many of the pitiful cases gathered in here are of the workers' class; but when the condition permits, instruction is given in some form of employment that shortens the weary hours and promises remuneration. A tuberculous girl was made happy recently when the Guild disposed of a piece of lace she had learned to make in the hospital—her first attempt—for the sum of \$2. On her second piece she was able to put a price of \$3.50. The cheering effect of this new interest was noticeable in her improved health and spirits. A young girl, partly paralyzed, having one good arm, runs a passenger elevator which moves slowly and is never crowded. She is pleased and proud to be useful and self-supporting.

Occupational therapy is systematically practiced at the vast St. Jean de Dieu Hospital for the Insane, conducted by the Sisters of Providence. In the bi-monthly review of cases by the attending physicians and sisters, special attention is paid to the allotment and regulation of work from a therapeutic standpoint.

Two thousand patients are housed in the bright, cheerful pavilions. As many as possible are trained to work in the different departments. On a recent visit I found them preparing the meals, washing dishes, polishing floors, working in the garden, gathering apples in the orchard; also doing dressmaking, tailoring, carpet-weaving, painting, and a hundred other useful things as well as, if not better than, the average normal worker of the same grade. Musical and dramatic talent is carefully

cultivated and artistic leanings are encouraged. One patient makes remarkably good mosaic work from the horns of cows killed in the abattoir. The material takes a high polish and is built up into vases and other decorative pieces.

The Sisters of Providence have also obtained good results in classes for epileptics. In the Hospice Gamelin, young girls afflicted with this disease are trained to work in the dining room and to help with housework. They also follow regular studies at stated hours. In the country house at Belocil, an open-air school for incurable children is in charge of sisters who have been trained in Belgium, Switzerland, Germany, and Paris. They are most practical and able to report marked improvement in cases committed to their care. Gardening is the favorite occupation, each child having its own little plot to cultivate. They are made to feel at home and happy, with opportunities for self-expression in painting, singing, acting, and other cheerful diversions.

Their work has to be varied, however, and the results are not permanent. It is costly, and yields no return. These cases must be artificially supported, mentally and spiritually. Left to themselves or removed to less favorable environment, they deteriorate, and when brought back to the home are in a worse state than before. Meddlesome people with good intentions but misplaced sympathy sometimes seek to interfere with the plans of the sisters, with sad consequences both for the patient and the community.

The infinite patience of the sisters is attested by the fact that when a patient is recognized as of the unteachable class—unable to do anything at all—the expedient is tried of giving her something to undo, often with complete success. Tearing up rags for carpet weaving, unraveling socks, or ripping up garments to be remade is congenial and useful occupation for those who have a taste for destruction.

The Sisters of Providence follow up their work by visiting the homes of the poor, giving relief, or nursing service as required, and finding employment for those who are able to work. Their anti-tuberculosis dispensary, the Bruchesi Institute, is an important health center at the East End.

The Sisters of the Good Shepherd confine their efforts strictly to reformatory work among girls and women. The delinquent child, the wayward girl, the victim of

alcohol or cocain is received as a voluntary penitent, or is committed to the institution for a term by order of the court. Cases requiring medical treatment are, therefore, not received. Occupation is the rule for every inmate. Laundry work and gardening have been found most beneficial for alcoholic and neurasthenic cases. But it is hardly possible to name an indoor industry which is not practiced under the supervision of these devoted teachers and saviors of human derelicts.

The Sisters of Mercy, in their splendid Maternity Hospital for unmarried mothers, make a long period of residence a condition of admission. The patient receives valuable training in nursing, domestic service, needlework, or clerical work, according to her aptitude, and is physically, mentally, and morally rehabilitated by the period of wholesome seclusion, study, and practical work under skilled supervision.

The debt of gratitude the community owes the sisters cannot be overstated. An imaginative social worker has drawn a lurid picture of the effect on Montreal of turning loose the ten thousand or more inmates of the homes and hospitals conducted by the sisters if these devoted women should elect simultaneously to retire from social service into the bosom of their families. The procession of our aged, incurables, demented, orphans, paralyzed, delinquent, tuberculous, epileptic, deaf mute, and blind fellow citizens would surely help us all to realize the nature and extent of the sacrifices being made by these noble workers whose names are not even permitted to be mentioned in public. The complete statistics of their deeds of mercy shall not be known until the Recording Angel is pleased to reveal them.

Meanwhile, as there are doubtless some persons who would be more impressed by the opinion of a living authority still in the flesh, I am pleased to quote the tribute paid to the hospital managed by our Catholic sisters, by John D. Rockefeller, who said on one occasion:

"That they have surpassed all other organizations in economy of administration and faithful performance of duty is acknowledged by the governments of many states besides our own, who are glad to entrust them with important responsibilities."

THE CHAIRMAN: We are now going to have a discussion on this subject by Miss N. F. Cummings, managing editor the Hospital Social Service Quarterly, New York City.



MISS CUMMINGS: Those of you who heard the paper read yesterday by the Sisters of the Grey Nuns, will remember that she said that if a shorter time could be taken to organize a social service department, it seems to her there would be established among the organization a much higher spirited organization than we have at present in our own social work.

I had a chat the other day with Dr. Sampson, and he expressed it a little differently. He felt that was a very, very pressing need. I had a fairly long talk with Miss Barry yesterday about her work, and she rather embodied a combination of the spiritual and practical welfare. I feel that that is also somewhat true of Mrs. Duggan, who is doing the social work in our institutions in New York City. I find that the policy of Mrs. Duggan and Miss Barry is quite similar; they both make placements by telephone.

I have been asked to speak briefly on the Placement of the Handicapped as carried out by the Hospital Social Service Association of New York City. This work as organized by Mrs. Duggan has been a practical success because of the fortunate combination of an energetic and well informed worker with a gracious personality, and a strong committee who joined with her in courageous vision. The placements of cardiac, arrested tuberculosis, psychopathic, and other patients referred chiefly from the Hospital Social Service Departments of New York have resulted in earnings to these workers of as high a total as \$7,500.00 a month for the group. These persons would otherwise have been dependents. The placements have been in normal industries in New York and suburbs, and briefly they include the following trades: Fountain Pen Factories, Jewelry (Wholesale), Architect's office, Hotels, Wholesale Grocers, Tobacco Companies, Can Factories, Automobiles, Western Electric, etc. The moral and physical effect of getting work adapted to their work tolerance has been good. As Dr. Winford Smith said in his discussion, "This has been given little attention heretofore." When I think of the personalities of the people I have watched from my end of the office on the corner of Forty-second Street, filing in to the appointment with Mrs. Duggan,—you all know what they are,—and I think of her gallant service in giving them the impetus to try out work that is selected for them, I sometimes think she should have a small sprig of laurel in the victory hall that is planned across the way in Pershing Square.



I want to outline very briefly the high lights of some of the other handicapped work I have seen recently. The Red Cross Home Service of St. Louis has a placement Bureau which operates very much as the New York Bureau. Barnes Hospital holds clinics weekly for the applicants, that they may be examined and advised as to suitable work. The Red Cross Home Service of Detroit has a similar department which is allied to a school for occupational training. Basketry, wood, metal, needle and other work is taught. In addition the plan of placing the applicants in normal industries is strongly supported. A rather fine measure developed in this branch has been the formation of a special advisory committee of blind persons who have placed other blind workers in factories, where they assemble parts of autos. Some have earned \$6.00 a day. They do not assemble a transmission or an ignition system, but parts of grease cups, gaskets, etc. Mr. Dresden, a blind man is executive secretary of this committee and also in charge of the information bureau of the home office, around which much social life is created. The committee appeared before the City Council recently and put through a measure to get the blind and other handicapped away from street begging and at normal work. This committee took an active part in the recent conference on employment in Ottawa. The strength of the work lies in first allaying the condition of mental panic of the handicapped person, and proceeding with reasonable modifications as with normal people who are seeking work. At the Michigan Mutual Hospital in Detroit, which is operated solely for industrial accident cases of the Michigan Mutual membership, the plan is to unite in the personnel of the staff under Dr. King, Superintendent, a man of social experience and a former McGill University man, certain elements which combine practical business value and a fortuitous psychology. The supervisor of Industrial Rehabilitation has a desk opposite Dr. King's. Injured men are quite unlike medical cases many times, and are soon ready to consider readjustment, which begins in the hospital in this instance. A social worker is available for follow-up. The Red Cross School of Occupational Therapy cooperates by placing an instructor in the wards for part time.

The outstanding factors for success in these various methods of handicap placement are: First to establish a normal mental attitude toward work, then examination for tolerance and the type of work advisable, advice and

assistance in obtaining the position, adequate follow-up by the social service department responsible for the individual. These results are not achieved without meeting the "bunkers on the course," as Miss Barry put it to me, but the results speak for themselves.

THE CHAIRMAN: We will pass on to the next subject. Mr. Davis will present the subject of the survey.

MR. DAVIS: Madame Chairman and Friends: I imagine that some of you were present this morning to hear the brief report given, and you will hear from Dr. Richardson fully as to what happened in the survey on her travels.

There are certain problems which seem to me to have been more or less merited in the discussion of our committee.

Perhaps, first of all, is the problem which the committee of 16 or 17 people coming from different elements interested in social service, naturally present, namely the problem of agreeing amongst ourselves.

Our committee on the social service survey includes sixteen extremely nice people coming from hospital social service, nurses, general social workers, medicine, hospital superintendents, trustees, with all the different points of views which can be held on such a subject as hospital social service. There are very many of them and if you take even sixteen varieties of them, and put them around the table, the problem of securing an agreement upon all of those questions is considerable.

We all, however, agree, that it is not easy to agree, and now, that is rather a hopeful sign because in committees, generally speaking, the things we all agree upon cease to be interesting things. The things we do not agree upon, and really get into a friendly kind of a row about, are the things which are in rather a developmental stage, with interest which attaches to the developmental stage of anything.

Some of the disagreements on questions upon which we find it hard to reach an agreement, will be settled by the facts which Dr. Richardson will present.

The facts were briefly referred to this morning, and the Social Service Department seems to me, speaking for myself, to be very nearly final and show that among those of practical experience no real difference is made in the selection of the personnel, in many representative departments, or as to whether the workers have had nurse's training or whether they have not. If people wish to argue that from a purely theoretical standpoint, that such

and such a label should be pasted on a person before they are allowed to go into a certain room, I am willing to argue that for the purpose of arguing, but when there is no distinction made in the practice in the field, there is really no use in arguing, and it takes us this far at least that the burden of proof is on those who want to paste the label on people before they can get into particular rooms that are dealing with social service.

That applies to another problem that is a real problem, perhaps, and a more difficult one raised this morning by Miss Cannon, namely, "How far shall the social service worker be an administrator?" I think that is a problem that obviously will arouse a discussion on Dr. Richardson's facts. It is a problem we ought to discuss. I will try to suggest something to do, in a few moments, as regards one of the ways of helping to answer it.

But, perhaps the outstanding problem from the standpoint of the worker is the problem of what might be called "Fitting in."

I have just come from a hospital here which will celebrate its one hundredth anniversary next year. Now the hospitals like thousands of institutions which are hundreds of years old, have well established traditions, and suddenly to expect them to take new themes, and to throw them in and expect the machinery to automatically digest them, so the cogs will not slip and catch one another,—to expect this machinery to suddenly adjust itself to the new type of work, is going farther than we can reasonably expect to.

Now, the problem comes down to the individual worker. A great many stories come to us in this committee about that; about individual workers struggling to fit into a situation. That problem of how to fit one's self into a department is a great problem. "Fitting in" seems to be helpful. If you are not helpful to the hospital, and the patient, and the doctors and others, you will not be there very long, but how to be helpful when there are thousands of things to do, and there are not more than 24 hours in a day, is a pretty difficult proposition, you do not want to work the entire 24 hours of the day, if you can help it, in fact I do not suppose you want to work more than perhaps eight hours in the day, and how to meet all the demands which other people make upon you, and the other demands which you know you want to meet, make it pretty difficult.

I do not believe that we can settle many of these prob-

lems on how much the social service shall do until we reach a clearer understanding of what the job is. I believe that at bottom the work must be largely the work of the people, who are themselves doing the job. I believe that the workers of the social service department in their own thoughts about their own work, in their reports of their work, can make the largest contribution to the solution of the problem of what the social service department is. It is very easy, and perfectly possible, to draw up a lot of rules like a political platform, on the subject of the social service dispensaries. Recently we have all read one or more than one of the political platforms, and we know that we can make a very pleasant form of work, and we know how far that will take us, or our country, or our state, or our next President, in the actual performance of certain duties after next March.

We know that, in other words, a statement of distinction will not take us very far unless you and I have in mind just what that distinction means in the concrete. It is all very well for us to agree that the social service work is foundationally related to the medical care of the patient, but we have to see the complications of that, and that will work out in some features.

I believe that despite the sixteen varieties of opinions that presented in our committee we shall come to an agreement on the statement of the social service—of what the social service is in the hospitals or dispensaries, and that is one platform—a political platform, if you please,—but to make it mean anything in the concrete will require the slow working out in the years to come. The trustees, the superintendents, and the staff, as well as the social workers, must understand what it means so they will do their part of this difficult process of “fitting in.”

Now, another problem that appeals to me very strongly, coming out of this survey, is the problem of keeping one's head above water when we are swamped and nearly drowned and gasping in the midst of a flood of duties and demands that comes to the hospital workers. The answer to that is just the same, it is an analysis of the job, and an analysis of the real meaning and implications, so there is the question there where to begin, and where to stop, and I feel that the American Hospital Association and the social workers themselves need the help of the workers in the field more than anything else.

One of the problems which appeals to me very strongly from the standpoint of an administrator, and thinking of

the American Hospital Association (which is primarily a group of administrators in its original function) is the problem of adjusting the idea of social service and the organization of a social service department in all institutions.

It demands understanding both on the part of the patient and the workers. I do not believe that the lack of understanding on the part of both the patient and the workers is always one-sided, but I do think that oftentimes they are both partly to blame, and it seems to me that in carrying on this work successfully, we should make a special effort to see that the friction between social service worker and the hospital administrators is reduced to a minimum, so that the greatest benefit may accrue not only to the social service department, but to a hospital as well.

I remember a conference I had a little while ago with an administrator of a large hospital, who said that it caused him a great deal of anxiety and stress of mind, to see the friction between these two classes of hospital work. He said, "I am tremendously in sympathy with what the department is trying to do, but one thing I am asking of you is to pay particular attention to seeing that the hospital affairs do not conflict with the work of the social service department,—that the hospital affairs in regard to the medical care of the sick and the prevention of disease, and the doing of any kind of social work do not conflict. It seems to me there must be a light thrown on this, and I blame the social service department for not distinguishing between the social service worker and the hospital."

This man was suffering some distress of mind, because he did not feel that the social service department of the hospital appreciated the relationship which it ought, and he was very anxious that that part of our committee's report which is confined to relationship between social service and the administration be worked out, because he said, "That is where they need a better understanding."

Or, possibly we could get some votes in favor of the reverse statement from this audience. I would not argue with you on that fact, for a moment, but it seems to me that both sides need a great deal of patience and tolerance along that line, and I think we run a little bit of danger of a too rapid development of a sense of professionalism. I think we are in a very definite danger of over-profes-

sionalism—an over-professional attitude and over-professional emphasis in medicine and nursing, and perhaps in school teaching, too. One the whole, social service in the hospital, which is the youngest baby in the hospital family, needs to remember that it is still on sufferance. I do not mean that you should cast aside professional standards or feel we have nothing to go on, but you should stand up for certain things which you believe to be necessary in the work, and I do think there is a certain danger (and this is one of the real problems) that will arise in this survey from the over-emphasizing of professional segregation of the social workers, as distinguished from other professions.

However, we all agree that in running a hospital one of the difficulties is the fact that you have several very highly specialized sets of people, doctors, nurses, social workers and pharmacists and so on; people who are professional people, and very highly specialized, and the task to keep these professional groups working happily together, and free from personal bickerings is a rather difficult one.

I want to close with this word. I feel very profoundly myself that the social service has proven by this little committee of sixteen, that doctors and nurses and laymen and professional hospital social service workers are getting together, under the auspices of the American Hospital Association, and has taken a step, even though a slight one, in getting a larger mutual understanding, and if we will concentrate our attention upon the job which has to be done, and which after all is the serving of the community, the serving of the people, and the serving of the sick and suffering, and in better helping humanity as a whole, some of these bugaboos and difficulties will disappear, and the patients and tolerance which we so badly need in the working out of these technical problems will take their place.

THE CHAIRMAN: The discussion on the problem of the social service survey will now be presented by Dr. Anna Richardson.

DR. RICHARDSON: The departments covered were 60 in number. The size of each department varied. In all there were 350 workers, paid workers, in these groups which does not include the clinical force. Eight of the hospitals had one worker, ten have two workers, seven have three, twelve have four, three have five, five have six, four have eight, four have nine, one have eleven, and seven have 15



or over. In regard to organization, 31 of the departments were organized as part of the Hospital Dispensary, with which they were connected and were also financed as such. The other type of organization is of various kinds. In some cases they were supported by outside organizations, and in some cases by a committee. 24 of the 60 departments have official committees or committees that are supplying the funds. Of these 24, 17 were committees of ladies, three were composed of managers, and three serve only in an advisory capacity, and 11 were raising funds.

Regarding the responsibility or authority of the social service, and the authorities to whom the workers were responsible we found that 33 were responsible to the superintendents only, ten were responsible to some outside organization and 14 were responsible to the superintendent and some other group and three were entirely responsible to committees.

The accommodations of the different social service departments, of course, are very varied, but seem too crowded. In the investigation which we made, we found that 37 of them were seriously crowded out of the 60, which would be a little over 60 per cent, and ten were in poorly lighted rooms where more than half of the rooms were below the surface of the ground, and seven of them had no privacy at all. They were in an area fenced off with a low fence.

The type of work which was being done in the different social service departments, are listed rather in detail. I do not know just how to classify them, because the work was of so many varieties.

Some classifications may be possible in this wide variety of activities, but still we feel that they are very widely scattered. The majority of these relate to the care of the individual patients, his needs and in his relation to the hospital. Then we find also that some of them like the keeping of statistics and research work that is done has a very distinct bearing on the department of social service technique.

The third group of activities have to do with teaching the personnel of the departments and medical students, pupil nurses and students of social work to give them some idea of the purpose and functions of the hospital social service.

Then there are a few who have to do with the hospitals, in its relation to the community, which I have grouped under the fourth group.

In addition to this general information which I collected in the course of the survey, a certain number of questionnaires have been returned to me, and at the time I made out these statistics. At that time I had 114. I have since received some, and there will be a more detailed report a little later on. Of this 114, 80 per cent had some social training, 41 per cent of the entire group had taken the complete course, or at least one year. I mean by that, that they had given up their other occupations and were devoting themselves to the study of nursing and social service work, and 39 per cent had taken special courses. Of the 20 per cent left from the original 80 per cent, 15 per cent were graduate nurses and 7 per cent were college graduates, 41 per cent of this small group for this period in our questionnaires were graduate nurses, 15 per cent of the nurses were also graduated from the schools of social work, and 53 per cent of them had taken special courses, of one kind or another, of which two were college graduates. 32 per cent of the original group of 114 were college graduates, and 14 per cent were graduates of schools of social work, and 36 per cent had taken special courses. There were 27 per cent neither college graduates nor nurses, but who had had some special training, 58 per cent were graduates of schools of social work, and 42 per cent had taken special courses, 15 of the entire group of 114 had special advantages in music and art or in the drama.

Now, regarding the pay of social workers. Out of 114—110 reported, 8 per cent were getting \$1,000 or under, 16 per cent were getting over \$1,000 and up to \$1,200, 38 per cent were between \$1,200 and \$1,500, and 12 per cent, \$1,500 to \$1,800, and 6 per cent were getting over \$2,100. There were none of that group between \$1,800 and \$2,100.

Of those who were getting a thousand dollars or under, there were 15 per cent of the college graduates, 2 per cent of the graduate nurses and 9 per cent of the group who were neither college graduates nor nurses. Two-thirds had been in the field for less than a year, and the other one-third were some volunteers who were college graduates, but who had grown up from volunteers and had assumed small positions.

While the social service work has no very definite standards and while it is not possible to get the needed number of workers, it is not the best time to attack the wage situation. Education must be arranged for first, and some clearer understanding of just what the work is. At

present, and probably always, there are certain phases of the work that can be done by persons with inherent ability, but no special training, under adequate supervision. The institution should have the financial advantage of using these persons. Some of them, just happened in, and offered their services, but they profited by the experience of others, and turned out to be most excellent workers, while quite a number of them came in because of some special interest which they had in the work. 70 per cent of the workers felt that they were making financial sacrifices to remain in the work. Now, in regard to overtime, I was very much surprised to see the tremendous amount of overtime. Only ten per cent reported no overtime at all, 28 per cent reported a little overtime, about two hours a week, 45 per cent reported that they had from two to five hours per week overtime, and 17 per cent over five hours per week.

Now there was a question on the questionnaire which you probably remember, as to whether you regard the time wasted which you have spent in studying this work. 64 per cent of them think that the time is wasted, while 36 per cent of them voted "no." Of these, the majority felt that there was entirely too much time spent on records and expressed a desire to do more home visiting. There was one of them who desired very much to have more time for her records. A large number of this group felt that their time was not advantageously arranged, and the head workers agreed that it was not properly arranged because they felt that they were not giving the proper case supervision, and they felt that they needed some additional assistance or some relief in some way.

In the survey, I had a good many conferences with different people, such as superintendents and head nurses, and physicians who were working on the job. We did not have these conferences in any formal way, but wherever it was possible I interviewed them and gained some very good ideas from them.

From conferences with the superintendents, I got the following ideas as to what the superintendents feel social service work is. First, a group concerned primarily with the general welfare and comfort of the patients. Second, workers who see that the patient gets all we have to give. Third, a department to exercise judgment when the social or economic relations of the patient are concerned. Fourth, to see that the patient has some place to go when he leaves the hospital. Fifth, to help the hospital to adapt

itself to individual means. Sixth, a group to amuse the patients and make their supporters feel they are doing something useful. Seventh, to further the ends of medical treatment.

The head nurses feel, one, that it is a department to relieve the nurses of the friendly services that are now crowded out. Two, to keep patients from worrying about their homes. Three, to see that patients are kept in touch with their families.

The doctors feel that the social service work is—

First, useful in saving money for the hospital by determining financial status on admission.

Second, to take care of the cases that bother you to death.

Third, a salve to the conscience when cases have to leave.

Fourth, happily disposing of chronic cases.

Fifth, an invaluable asset in arriving at a diagnosis as to the casual factors in a patient's condition.

Sixth, a great satisfaction in rounding out our cases to completion.

Seventh, the big part of dispensary work to which the doctors contribute technical skill and lastly, the leaven starting the socialization of medicine.

Now, as regards the workers themselves, we sent the workers the questionnaires, and I have copied a few that were taken at random. I have not studied these answers as yet in detail. They are as follows:

First, to study causes of illness and poverty to aid in the establishment of agencies to meet needs and to work for prevention.

Second, to aid in medical diagnosis and treatment, that is cure.

Third, to encourage confidence in the medical treatment and the continuance of same until benefitted.

Fourth, to be a sort of gobetween between doctors and patients, from the medical viewpoint.

Fifth, helping to socialize medicine in cooperation with medical men.

Sixth, preventative, inability to pay for medical care, first symptom of poverty, if well met can head off dependency.

Seventh, judgment between sick persons and environment.

Eighth, helping people to see their problems clearly,

removing largest obstacles so that they may do the final solving of their problems themselves.

Ninth, to combat the venereal disease situation.

Tenth, to acquaint the physician with the facts that will make it possible with a true understanding of patient's social background and present problems to properly handle the matter. To see that the patient is adjusted to his environment, furnish intelligent medical information to other agencies in the community, to develop social vision in members of the hospital board, and the financial committee, to correct conditions in the home, and to raise the standards of health. And these can be carried on ad infinitum.

These will give you an idea of the variety, which we will group and classify later.

THE CHAIRMAN: Miss Cannon is going to give us a word of discussion regarding this problem.

MISS IDA M. CANNON: We, in the United States, have been accused of being particularly interested in making surveys, but not particularly interested in what we would do about it.

I think those of us in the field who have heard this report today must feel a real sense of obligation of what we are going to do.

There are two or three things which I want to emphasize. I believe if we had, 15 years ago, taken in one type of person only, we would have lost much. Now, it is obvious, as time goes on, and there are more social service departments demanded, that we have to face the problem of the training. We have to add to the curriculum. I think we want to be very careful in our methods of training.

Mr. Davis spoke of the danger of provincializing. If provincializing means rigid technique, that eliminates the spirit, we do not want it. We would rather get along with untrained volunteer service.

MRS. MALLORY: Madame Chairman, Miss Cannon has asked a question which I would like to try to answer. She has asked what we need. First, I think we need an advisory committee, a committee well informed on hospital social service, that will be prepared to present to any new worker a program. One of my greatest needs in organizing my department was lack of program. This committee could give advice on organization and on special problems. It could also give a simple but comprehensive program. We also need, I feel, a school for workers, not only for the

social service workers themselves, but a school that will give additional training which might be of great service. This training might consist of a few lectures, perhaps given for doctors in training, nurses in training and social service workers in training, for I feel the need of a common ground of understanding amongst these three professions.

THE CHAIRMAN: We are now ready for the business session. According to the constitution this session must elect its chairman and secretary. This is usually done by nominations from the floor. Are there any nominations for the chairmanship of the meeting for the coming year?

Miss Ruth Emerson was elected chairman for the next year and instructed by vote of the section to select a secretary.

Adjourned.



## AMERICAN HOSPITAL ASSOCIATION

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, Canada

Round Table, October 7, 1920, 2 P. M.

Mr. Asa Bacon in the Chair.

**THE CHAIR:** The Round Table Sessions are conducted to afford opportunity for the delegates of the American Hospital Association to get together and discuss difficult problems on hospital administration.

As this session will be in the form of a question box, no papers will be read, nor will there be any lengthy speeches.

As rain was badly needed in the district, the followers of a darky evangelist approached him with the request that he hold a special service to pray for rain. The day arrived, and the church was packed with people from far and near. Ascending into the pulpit, the evangelist thus addressed his flock: "You people will all get mighty wet today 'cause you hab no faith. We hab assembled here to pray fo' rain and not one of you hab brought an umbrella."

Now you have come from far and near. You have nearly packed the church, but you differ from this flock who gathered to pray for rain, inasmuch as you have faith in the Round Table Session. You have brought your umbrellas in the form of scores of questions. I hope your ardor will not "be dampened."

Last year, some of the members felt that the Round Table discussions did not bring out any information of value; that we did a lot of talking but arrived nowhere. It seems to me that if a question is answered to the satisfaction of the party asking it, we have given information of value at least to the member concerned, and this is the purpose of these sessions.

This meeting is entirely in your hands, and I am anxious for you to discuss your various problems fully and freely. If, however, any delegate does not have his question answered to his satisfaction, he can bring it up in the evening session or before the Advisory Committee tomorrow. It is the desire of the officers of the Association to have no member leave this convention without receiving

all the information and assistance he came for. These sessions are, as I have said before, "Get-together meetings," so let us not only bring out all the valuable information we can, but let us become better acquainted with each other.

These questions have been divided into sections and the first will be on Nursing. We take this up first because there are so many who have been invited to tea, at about 4 o'clock, so we want to get through with this subject before that time. The first question is, "What is the responsibility of the hospital in meeting the demand for nurses?" Doubtless some of these questions will appear rather peculiar to some of the members, but I am reading them just exactly as they were put to me, and the party asking them would probably like to have them answered according to the way the question has been asked. I might add to that, "What is the method of procedure that has been found to work best in the affiliation of smaller with larger hospitals, with regard to the nurses?" That question was pretty well answered at last night's session. In addition to this same question, "Should the entrance requirements be lowered, and what should be the attitude of the superintendent toward nurse education?"

MISS McMILLAN: Is it not the responsibility of the hospital nurses' school to educate the young women when they arrive at school? Is it not the truth that for too many years the hospital has felt itself entirely responsible not only to educate the women but draw them into the school? Could we not get better results if we made the people in the community realize that it is their responsibility to secure the women and send them into the nurses' schools so that the raw material may be provided by the lay people and the hospitals may turn out these women as expert nurses? It seems to me that in the task, we have assumed all of the responsibility, and I believe that that is one of the troubles; we have tried to solve too much ourselves, without sharing our troubles with the lay people in our different districts, and can we not make the friends of the hospital, our women's boards and our men's boards and the other lay people in whatever communities we are, realize that the duty of the nurses' school is to educate, not necessarily to produce the material to educate?

THE CHAIR: Anyone else? We want the ladies to take part.

MR. RICHARD BORDEN: I am considerably interested in

seeing this same question come up every year. I cannot understand why, in this day and generation, that question has not been answered in times past. It is of no value at the present time, from my point of view. Just as quickly as it can be done, the standards of the nursing profession and their education must be raised instead of lowered. It seems to me that with the advent of new methods in nursing which I am sure are bound to come, especially in the hospital, with the demand for intelligent women educated in the nursing profession, with all that implies, the great demand of the future is going to be for nurses with the most thorough preliminary education and the most complete education in their profession. It seems to me that the answer is clear, that under no circumstances should the requirements of nursing people or the requirements of the education before coming to the training school or after—in any degree be lowered, but should be made more and more strict as the opportunity comes and as the opportunities for achievement in the nursing profession become more fully recognized among the high-class and intelligent women who may, I hope, in the near future, be available for this service.

MISS McMILLAN: What was the third question?

THE CHAIR: What is the method of procedure that has been found to work best in the affiliation of smaller with larger hospitals, with regard to the training of nurses? I think that was pretty well covered last night, unless some one else has something to say.

DR. BIGELOW: May I ask that this question with regard to lowering the standard of nurses, be put to a vote, by all the superintendents present, to vote yes or no? It would take but a minute.

THE CHAIR: Dr. Bigelow asks that the question be put to a vote to see how many are in favor of lowering the standards. All those in favor of lowering the standards will please stand up.

MISS ROSA SAFFEIR, of Jamaica, Long Island: The standards are different in different states. New York state has one year in high school.

THE CHAIR: If we take it by states, we will be all the afternoon.

MISS SAFFEIR: How can we decide how to lower the standards when different states have different standards?

THE CHAIR: Do you want it voted by states?

MR. BIGELOW: No, just a popular expression.

A MEMBER: I think you misunderstood the lady's

point; I think her point is that in some states they have a higher standard than in others.

MISS SAFFEIR: Yes, that is what I meant.

A MEMBER: And therefore, when you are voting as a whole, your vote don't amount to anything, it is just a waste of time; if you are in a state which requires a girl to be a graduate of the sixth grade, you are voting for one thing; if you are in a state that requires a girl to be a graduate of the eighth grade, you are voting for another; if you are in a state which requires a girl to be a graduate of the tenth grade, you are voting for still another. I think that is the lady's point.

MISS SAFFEIR: Yes, I thank you for making it clear.

DR. BIGELOW: I withdraw my suggestion.

DR. MOSS: I would suggest you call for a vote as to how many are in favor of reducing the entrance requirement to less than a high school education.

MR. MORSE: There seems to have been a great deal of discussion in the past few years as to whether or not pupils shall be required to have a high school education or its equivalent. That subject has been very much debated, and it would be interesting to have an expression at this meeting. I would like to put it this way, how many are in favor of applicants being required to have a full four years' high school course before entering the training school?

THE CHAIR: Those in favor of a full four years' course will please raise their hands. Those who are not in favor. Those not in favor are in the majority.

MR. B. M. FOWLER: I now suggest that you call for a vote to show how many are in favor of at least one year in high school.

A MEMBER: There is probably not a member here but would be glad to accept pupils who have had training for four years in high school, but the fact is we cannot get them and so we take the best we can get. (Applause.)

THE CHAIR: I have been asked to have you vote on whether you approve of applicants that have had only one year in high school.

MR. B. M. FOWLER: I should like to get an expression in regard to that. The standard in New York state is a requirement that there shall be at least one year in high school or its equivalent. The question I would like to have put is, shall we reduce that requirement of one year in high school?

A MEMBER: I am not a high school graduate, did not

enter a high school and am not a graduate of a grammar school; because of home conditions, I was obliged to leave school, but I think in spite of all that handicap I have made good. I have been in charge of two hospitals. In my present hospital I have held the position of superintendent for something over thirty years, and I think there are many young women in the lower walks of life who will be qualified if given a chance. They are good women, but have not had the opportunities that the grammar school will afford in their locality, or the high school, because of their home handicaps, and I think that if any young woman will promise to make good, will study and do all that she is required to do to obtain the position of nurse, she ought to be accepted. (Applause.)

MISS McMILLAN: Is it not the case that there are always exceptions to every rule? Are we not, by putting our standards in the nursing schools too low, discouraging young women getting an education; if we raise our standard and persuade the young women to continue their schooling, they will do so and make every kind of effort to complete their education and will finally come into our nursing schools. I believe we will not only get into our nursing school a better type of women that we can make more out of, but we will be helping the educational situation of the country. If they are told that they have to have so much education, they will make an effort to go to a night school or go back to school, whereas other girls, if they think they can go into a nursing school at the end of one year of high school, simply don't want to continue their school work, and it is really beneficial to them in the end to be persuaded to continue their high school work when they very often could do so.

MR. BILLINGS: There are just two courses to take in this nursing proposition; one is the building up of the splendid girl to help mankind, whether she be a grammar school or high school or college graduate, and the other is to make the nurses professional people, like clergymen, lawyers and doctors. The line of demarcation is hard to draw. I should like someone to help solve that problem. Where shall we draw the line? Are they professional people? Do they spend their four years in college and come out with a college A. B., to become nurses, or do they assist physicians?

MR. FOWLER: The requirement in New York state, as I understand it, is not one year in the high school, but an education equivalent to one year in the high school, and I

am quite sure that the lady behind me, who was so ambitious and succeeded in carrying out her ambitions, could meet that requirement without going to a high school; they could get the educational requirements up to that point without the high school. The question is whether we are in favor of that degree of education or below.

DR. HUGHES: Is it necessary to have a college education in the United States of America? We would never have had the parcel post inaugurated by David Lewis, of Maryland, if a college education had been a prerequisite to public life. I am in favor of taking a woman who has been in the high school and giving her an opportunity to make up her credits after she goes into the institution. I saw a young woman recently who had one year in the high school, who was twenty-five years old and was determined to study nursing if she could get into a hospital, but who did not feel like going back and going through the other three years in high school; she could not afford it. She was a woman of fine character, of good intelligence, but without the amount of education required. I believe that woman will make a good nurse and if given the opportunity will make up for a lack of high school education in training, and I think she should have the opportunity.

A MEMBER: I think there is one phase that ought not to be overlooked, and that is, as hospital administrators, we ought not to say to the prospective candidates, "We advise you to go into a profession or into an occupation in the carrying out of which you will meet competition of a type for which you are not well fitted." I am thoroughly in sympathy with the attitude of the lady who spoke. She came through at a time when the competition was of an entirely different character, and the same was true with regard to medicine. The older doctors would not feel that they were fair to the prospective students today if they advised them to go into the medical profession, if it were possible, even legally, without the very best educational background possible; and so when we are talking about this nursing standard, as the basis of our admission, let us remember that we are not only to take into consideration the inability to get nurses now, but we are to take into consideration those who intrust themselves to our care, and it is due them to show that in the life that is before them they are to meet a type of competition



which is entirely different than it has been during the last twenty years. (Applause.)

A MEMBER: There is one thing we might as well take into consideration, that there are two things a man has got to have in this world to succeed; he has either got to have money enough to get along fairly well, or he has got to have brains. Take our successful business men of this country—hardly 10% of the male population get to college; of the successful men we hear of in the country, 75% are college men. The same rule applies in the nursing profession or any other; the more highly educated ones are the ones who are going to make their mark and make the greatest success. It is not a law that applies only to college men, it applies just as well to college women and people doing educational work along any line.

A MEMBER: There are only four states in the United States that require a full high school course before girls may become candidates for nurses' training schools; I think they are California, Louisiana, Maryland and Delaware, according to the last published report. I would like to have a comparison in our own lines between the nursing profession in these states and, for example, Pennsylvania, which, up to at least a year ago, and I think at the present time, made no requirement whatever for nurses in the matter of their previous education, but took any girls who were well trained and who had brains and ability and trained them further for their work. I may say that in the hospital that I represent, St. Luke's, in Cleveland, we require that every girl shall have had a high school course. We have no trouble whatever getting all the girls we want and we do not pay them a salary; they are glad to come, and I believe that the standard of the training school itself will have a large bearing upon getting the number of girls who are best equipped, best trained. I think we can get the high school graduates if our training schools are in good running order, well equipped and are the very highest and best standard. (Applause.)

A MEMBER: I am speaking for Virginia. Our standard is one year at high school. However, the school over which I am executive requires a full high school education or its equivalent. We have enough pupils and we are the only hospital in the state that requires this full high school education and has enough students.

A MEMBER: May I say, for the gentleman's informa-

tion who just spoke, that Pennsylvania now requires one year in high school.

MR. FOWLER: The purpose of these series of resolutions or questions is to determine whether any educational requirement shall be insisted upon, and if so, what; and it seems to me that the minimum requirement should be the high school year or its equivalent, and the question is, do we want to lower that requirement? That same requirement ought to be insisted upon to indicate what education the candidate has, so I would like to have an expression in regard to the one year in high school as the minimum requirement.

MISS SAFFEIR: Who can explain to us why there has been a shortage during the last twelve years? There has been a requirement of one year high school in New York state, yet for the last twelve years we are all short of nurses in New York state. Will the larger hospitals in New York City tell us why they are short of nurses and only one year in high school required in New York state? Is it not a fact that all our hospitals in New York City are short of nurses and have to employ graduates and pay six dollars a day to the ward teacher? Why is it? It is not a criticism that I am making, but I want information. What is the trouble? Are we at fault or is the economic situation at fault?

THE CHAIR: I have been asked to get an expression of opinion as to whether we should reduce the educational requirement of one year in high school or its equivalent, or make it less? Those in favor of one year in high school or its equivalent, as a minimum, will please raise their hands. Those who are not in favor of that requirement will so indicate.

(The affirmative vote was unanimous.)

MR. DANIEL TEST: I cannot give any solution to this subject, but I do want to sound just a word of caution about being too pessimistic about the nursing situation. Prosperous times has a great deal to do with it. Some of you may think that is not the case, but if you will go back to 1888 and 1890, there was a dearth of nurses, but in 1893 there was no dearth of nurses. There is a dearth of nurses in prosperous times. In the depression of 1893, the hospitals were flooded with applicants, and when prosperity came back to the country, there was again another dearth of nurses and when we had another depression, there was another influx. Now we are having prosperous times, and I believe that has a great deal more to do with

it than some of us think. To be sure, many of our hospitals must furnish the nurses better living accommodations, shorter hours, better instruction, but another thing we must do (perhaps, I am saying the same thing that was said at the meeting last night, I don't know because I was not there), is to educate the public to the fact that they have a responsibility in maintaining these training schools and that they have some interest in getting the young women of the country interested in the work. When a person comes to a hospital and demands a nurse and thinks he ought to have a nurse at any time, and still feels no responsibility for the maintaining of a training school or hospital, it is not fair, and that is one of our jobs today, to take this message to the public.

THE CHAIR: In line with what Mr. Test has said I was asked last night if I would, before this meeting today, give you my opinion on the nursing question, and in order to confine it to as few words as possible, I wrote out something here that I want to read to you. Mr. Bacon then presented the following:

A three-year course is necessary to produce a nurse properly trained and properly fortified to meet the demands of the present generation. *Mature judgment and efficiency* are the most important qualifications of a nurse. These you cannot develop in the average girl in two years, especially by the admission of young candidates into our schools. No doubt there are some exceptionally bright girls who can absorb enough in two years, but the large majority of students require a longer period to qualify themselves to meet the demands of an exacting public.

In general, I believe that the principles laid down in the three-year courses of our schools are meeting the demands of the public, except in the shortage such as we are experiencing in all vocations. Of course we will have to make changes to meet the changing conditions of the country, but each social change is toward higher standards, not only in living but in education and in everything that touches the physical and social life of our people. Why should we lower the standard of the nurse?

As superintendents, we should consider what the relationship of the hospital is to the community. It seems to me that our first duty is to properly care for the sick in the hospital, and in so doing we must have efficient nursing.

I want to say that I believe in community service and all that, but our first duty is to take care of the sick in the hospital, therefore we must have efficient nursing.

There is no argument that the third-year nurse has more mature judgment than the first- or second-year girl. She can be placed in much more responsible places. The three-year course stands not only for greater economy but

greater efficiency in the hospital because the turn-over of pupils is less.

The public is very much interested in their sick being properly nursed, but it does not encourage its own daughters to take training. The people do not seem to realize that it is just as important to care for the sick of the community as it is to conduct the business of the community. If we in Chicago had to depend upon our own girls to fill the training schools, we would have to close our hospitals unless we could arouse our people to fulfil their obligations to their sick. It is the mothers and fathers who are partly to blame for the shortage of nurses inasmuch as they want some other girl rather than their own daughter to care for their sick. The responsibility rests with the community and not entirely with the hospital. We cannot get girls unless the parents will send them to us. Nevertheless, the parents are not altogether to blame. They have not been sufficiently educated. It is the duty of the hospital to set its standards right, then educate the people. Pre-nursing courses are valuable, for they are a big factor in educating the student and the parent.

I am in favor of high standards, the eight-hour shift, and the three-year course, with an allowance of a-month-a-year vacations and one month for sickness.

THE CHAIR: Is there any further discussion? We have a few more questions on this subject: "What are the salaries paid in the nursing department, director, assistant; night supervisor, operating room, wards, matron, etc.?" In answer to that question I have some figures from Chicago that I will read.

Mr. Bacon then presented the following table of salaries:

COMPARATIVE SALARIES IN NURSING DEPARTMENTS  
JULY, 1920.

		Some Chicago Hospitals.					
Director .....	\$125	\$175	\$333.44	\$...	\$275	\$300	\$225
1st Assistant .....	100	110	142.50	125	115	125	135
2nd Assistant .....	75	85	110	100	115	100	120
Night Supervisor .....	75	80	137.50	100	115	100	110
Dietitian .....	..	100	110	85	95	100	135
Head Nurse, Oper'g Room	100	90	125	100	115	100	115
Assistants .....	75	..	..	75-	..	90	..
				100			
Anesthetist .....	..	90	..	..	200	125	115
Assistant Anesthetist .....	..	..	..	..	125	..	..
Head nurse, wards.....	..	65-	80-	80-	..	70-	100-
		85	103	100		100	115
Matron, nurses' Home....	..	75	..	150	60	60	75
Social Service Head.....	..	..	150	150	..	100	140
Ass't Social Service Head ..	..	..	..	125	..	..	..

The above are monthly salaries with maintenance.

THE CHAIR: I have also been asked to get the figures that are paid nurses in Greater New York. First, how much do they pay their superintendents? Can we have that answered quickly?

MR. MORSE: Fifteen hundred dollars a year.

DR. WILSON: Fifteen hundred dollars.

A MEMBER: Greenpoint pays \$2,310 a year.

A MEMBER: Cumberland pays \$1,840 now with an increase the first of January.

A MEMBER: In the big city of New York, do they pay the superintendent of nurses the large amount of \$1,500 a year?

THE CHAIR: That is what they say.

THE CHAIR: Assistant superintendents?

A MEMBER: \$1,500.

A MEMBER: \$1,200 to \$1,800.

A MEMBER: \$1,446.

THE CHAIR: This of course is hardly a fair rate to give, because we do not know the size of the hospital, and I know that some of the large hospitals pay larger salaries than those quoted here, but I am simply putting the question the way it was handed to me. Night supervisor.

DR. WILSON: \$1,320.

A MEMBER: \$1,500; six hundred beds.

A MEMBER: \$1,500; one hundred and seventy-five beds.

THE CHAIR: Floor nurses.

A MEMBER: 175 beds, \$100.

DR. WILSON: \$1,200 to \$1,320.

THE CHAIR: Student nurses; do you pay your student nurses in New York City?

DR. WILSON: When you say floor nurses, do you mean bedside nurse?

THE CHAIR: I presume so. The question here is floor nurses.

DR. WILSON: Floor nurses we pay a minimum of \$72 per month.

THE CHAIR: I take it you do not pay your student nurses anything in New York City?

A MEMBER: In four training schools they get \$18.33 a month the first year and \$23.30 the second year and part of the third.

MR. DANIEL TEST: I think it is a mistake for this Association to talk about paying pupil nurses. I think if we would say that we give them a certain allowance for their books and uniform, it would be very much better. I do not think any of us feel that we are paying the student nurses, and for this Association to take that attitude I think is a mistake. I think it should be called an allowance for uniform and books.

MISS SANDERSON: I would like to ask a show of hands—

how many schools give an allowance and how many charge tuition?

THE CHAIR: How many schools give an allowance? (A large number responded.) How many charge a tuition fee? (A few responded.)

A MEMBER: The gentleman said that New York paid their students \$18.32 and \$23.33. They also give them books and uniforms and an allowance for shoes and pay for some other incidentals; that is what we give them the money for.

DR. J. G. WILSON: There was a show of hands to show the number of schools that gave an allowance, but there was no show of hands to show those that gave no allowance, so we are still without information as to that.

THE CHAIR: How many give no allowance? (About ten responded.) How many give an allowance of \$25 a month or more? (About eight responded.)

A MEMBER: Those who give no allowance, do they furnish the uniforms and textbooks?

MISS McMILLAN: I represent a school where there is no allowance paid; uniforms are not given; textbooks are not given; there is a registration deposit of \$10 before any young woman's name is enrolled for entrance into a class. I might say that the school has a large number of candidates and we are not short of young women; we have an allowance fund and a loan fund; any young woman who enters school, after six months' residence in good standing, who is short of money, is privileged to borrow money to be returned without interest after graduation.

THE CHAIR: We have so much other material that I think we had better pass on to the next department, which is Housekeeping.

MR. MORSE: I believe another word should be added on the question of nursing, which is rather vital. The fact of the matter is that most of the hospitals do give an allowance to nurses, and still, with it all, we all have a definite shortage. I am absolutely opposed to lowering the entrance requirements or reducing the standard as laid down now in most of the states of the country to a three years' curriculum; on the other hand it seems to me that we are dealing with an economic question which controls and operates throughout the country. As long as the high cost of living persists, so long, I believe, we will have a definite shortage of pupils in our training schools. The rank and file of the women who go into the training schools are women in moderate circumstances. Some of



the young women have definite responsibilities to their families, to assist them in making a living. Mr. Test has pointed out that we have a period of prosperity now coupled with high cost of living. I believe that explains the definite shortage. The question is, what are we going to do under the present circumstances? The hospitals are in desperate need of the pupils to go through the training and take care of the cases; shall we wait for the next year or two or three years until conditions change, or is there some other solution, and that is to offer, not wages or salary, but a larger allowance to these young women who come from poor families, to enable them to maintain themselves in comfort while they are in training during the year? That, it seems to me, offers a solution to the present difficult problem.

THE CHAIR: If there is no further discussion on the nursing subject, we will take up the Housekeeping Department. "How should mattresses and pillows be cared for?" (Laughter.) When you consider that the average patient occupies a bed twenty-four hours out of the twenty-four, that is rather an important question. Can anyone answer that? No answer.

THE CHAIR: The next question is, "How much brown soap, soda, soap powder, etc., would it be fair to use per patient per bed per day?" (Laughter.) For the benefit of those here, I will say that when this question came in, I spent a great deal of time in getting the information desired, because I realized that no one would come to the convention ready to answer the question. Last year, at the Presbyterian Hospital, the amount used in dollars and cents was \$13.37 per bed, or 3.7 per day per bed. That included laundry soap, all kinds of soap used in the institution, washing soda, etc. I do not know whether that will be of any benefit to you or not, but it answers the question. It did not, however, include the nurses' home. "What are the wages paid ward maids, porters, etc.?" Now that varies in different parts of the country. In Chicago the average runs about \$50 a month with maintenance. About how do they run in New York City?

A MEMBER: \$40 is the minimum.

THE CHAIR: Can anyone tell how they are running in the South?

A MEMBER: In Maryland we pay \$48 a month; that is in the U. S. Public Health Service Hospital.

A MEMBER: In Tennessee, \$36.

A MEMBER: In North Carolina, \$35 to \$40.

A MEMBER: \$40 and maintenance in California.

A MEMBER: In Georgia, \$18 to \$22.

THE CHAIR: Is that colored help?

A MEMBER: Yes.

A MEMBER: North Carolina is colored.

THE CHAIR: I think that answers the question; we will pass to the next; "Do you give internes a cash allowance?" I will ask those to raise their hands who give internes a cash allowance. Those who do not. Those who pay, please give us the amount. (Majority do not.)

MISS SAFFEIR: \$50 to \$75.

A MEMBER: Juniors, \$30; seniors, \$50.

(Other members responded, \$50, \$75, \$100 and \$50 a year.)

DR. WILSON: You want to differentiate a little as to whether these internes are there for learning or are hired for the purpose of giving service.

THE CHAIR: The question is those that are paying for the service of the internes, whether they are there for training or there simply for hire to do the work of the hospital. Suppose I ask those who are paying the internes whether you are paying them simply to do the routine work of the hospital, or whether they are there for training?

A MEMBER: We would not insult a physician by giving him \$25 as salary, but simply cigarette money.

MR. CLARK: It seems to me that we all take the internes to give them the training. My experience has been that with a salary, small or large, you have better control over your staff because there is a money consideration, and you can say thus and so to them.

THE CHAIR: Has anyone else anything to say on this subject? If not, we will pass to the next question: "How is your overhead for out-patient service calculated?"

A MEMBER: By cubical area:

A MEMBER: Twenty-five cents a visit.

THE CHAIR: I know of one out-patient department where they charge fifty cents a visit. "How do you finance your laboratory service?" We finance ours by charging a fee for any special laboratory service. Has anyone anything to say on the subject?

A MEMBER: We found that there was great opposition by our surgical staff, particularly to making a laboratory charge, so we increased the price of private rooms and make no charge for laboratory service unless the service is \$15 or over.

A MEMBER: We charge \$5 admission for laboratory fees.

THE CHAIR: That is for all patients, ward patients and private rooms?

A MEMBER: For everybody, for the routine work.

A MEMBER: Rochester, N. Y., makes no charge for laboratory service, either ward or private.

THE CHAIR: How much have hospital rates increased during the past year, private rooms and wards?" Now, to get at that, any of you that know about what percentage of increase you have made in the past year, if you will just call off—that is charges for the rooms and ward beds.

A MEMBER: 20%.

A MEMBER: 30%.

A MEMBER: 33 $\frac{1}{3}$ %.

OTHER MEMBERS: 25%.

THE CHAIR: I think the average runs about 30%, from what statistics I have been able to gather. "How do you liquidate an annual deficit?" (Laughter.) That is what we are all trying to find out. Can anyone answer that?

A MEMBER: I would like terribly to hear from the delegates as to how they calculate that basis of deficit. In the experience we have had, we have discovered that about 33 $\frac{1}{3}$ % of the cost of our patients, 150 to 200 beds, has to be made up by charity. How does that compare with others?

THE CHAIR: Can anyone answer that?

A MEMBER: That is ours, 33 $\frac{1}{3}$ %; we draw that amount from the community chest.

THE CHAIR: I imagine that the member asking that question probably has no endowment fund to draw from.

A MEMBER: It doesn't make any difference, if you draw from the endowment fund, it is simply charity.

THE CHAIR: We have another question along that line coming up later, that I think will answer it fully. In the list of general questions, a great many have been handed in prior to this meeting. "What wartime economies are still in force?" So far as I am concerned, they are all in force. I do not know of any superintendent that has let up any. "Do you provide any means of recreation for your help?"

DR. J. O. KOLB: Before you get away from the cost question, I would like to know what the average per diem cost is and what is figured in per diem cost? I think we ought to know here among ourselves what our patients are costing us.

DR. ENGLISH: I can answer that question for the four hundred hospitals that I surveyed during the past year; their average was \$3.40 per patient per day, including the cost of service.

THE CHAIR: Does that answer your question?

DR. KOLB: Yes, it does, in a general way; I knew the general answer, but would like to have some of the individual hospitals tell about it. I would like especially to know what figures the sisters have, and if they are lower than the rest of us, just why it is so.

THE CHAIR: The best way to get at that is, I think, to take a sort of a rapid fire and see how we compare. The Presbyterian, of Chicago, 437 beds, is \$4.10.

A MEMBER: The Presbyterian Hospital, North Carolina, is \$2.35.

MR. FOWLER: Vassar Brothers Hospital, at Poughkeepsie, is \$4.00.

A MEMBER: The Rochester General Hospital, 300 beds, is \$3.50 for ward patients and \$5.00 for private room patients.

A MEMBER: The Allentown Hospital, 275 beds, is \$3.25.

A MEMBER: My hospital, 200 beds, is \$3.25.

A MEMBER: My hospital, 225 beds, is \$3.27.

A MEMBER: The Municipal Hospital in Philadelphia, for the first nine months of this year, is \$2.90 per diem, gross cost, which includes all expenses.

(Other members gave the following figures: 75 beds, \$3.03; 250 beds, New York, \$4.60; 175 beds, New York, \$4.00; 175 beds, Youngstown, Ohio, \$4.00.)

DR. THOMPSON: The Toronto General Hospital, 444 beds, \$3.45 a day.

THE CHAIR: We will pass on to the next question: "Do you provide any means of recreation for your help?"

MISS KEITH: We have a welfare worker for our domestic department. She is a woman of varied resources, and needs to be. Some of the employes are being taught to write and read English; others are being taught arithmetic. They are given anything that they ask for that we are able to provide. They have a sewing machine, a piano, a victrola and a typewriter. One girl passed her regent's examination in algebra this last year. One of our waitresses has left the waitress work and is doing office work from the bookkeeping knowledge she acquired while with us, and some of them are studying music. They asked for it and it does help to make them happy and contented. They are taken out on picnics and build a fire and get

their supper and do things of that sort. They are invited to parties, and some of the men take part in the instruction.

MR. CLARK: That sounds rather pretentious, perhaps. In the smaller hospitals, simpler things could be done. In our hospital in Wheeling, the housekeeper saw that the maids, most of whom were Catholics, went to the evening parochial school; also that they had sewing classes and several forms of recreations were gotten up for them without any expense to the hospital.

THE CHAIR: Time allowed for vacation for different employes—we allow two weeks with pay after the first year.

A MEMBER: We allow two weeks with pay after one year.

MISS KEITH: What do you allow after three, four or five years? Answer: Two to four weeks.

THE CHAIR: Does anyone else give any vacation to their employes?

(Several members responded that they gave two weeks.)

THE CHAIR: I think the general average is two weeks with the older employes. I know with us we give a great many three weeks and some four weeks, depending upon the value of the employe to the institution. "Time allowed for sickness;" does anyone have any limit?

A MEMBER: Thirty days.

A MEMBER: Two weeks, and one month after two years' service.

THE CHAIR: "How may quiet zones be obtained around large city hospitals?" I would like to know if any member here has succeeded in establishing a quiet zone, that is quiet. I have not been able to do it.

MISS ROGERS: In St. Louis we have quiet zones around hospitals and they are established by ordinance, but a quiet zone does not mean anything, because you could not tell if you were in the neighborhood of a hospital at all, because the ordinance is not enforced. Complaint has been made to the department, but it has not been enforced.

DR. WILSON: The city of New York around a good many of the hospitals has laid wood pavement to do away with the noise of trucks, and I think those who operate those hospitals will agree that it does away with a good deal of the noise.

MR. CLARK: One thing is to get the ordinances; sometimes the council is very adverse to any suggestion coming

from a hospital; usually, however, they welcome it. In Wheeling we got it put through by appealing to a friendly councilman, and it went through with a rush. Within about a year we found a good deal of trouble with the noise, as much as ever. We had a policeman detailed for special duty for a couple of weeks and it settled down again for another six months, and then it was repeated. We never had to arrest anyone, although there were a good many threats to do so.

THE CHAIR: I might say that we have a very good quiet zone law in Chicago, but we cannot enforce it without assistance from the police department, and through a lack of sufficient policemen, we cannot get any officer detailed for any great length of time, so that the quiet zone law of Chicago really does not do much good to the hospital. "What is the comparative value of housing employees, discussing comparative expense as between the two systems?" This member, I think, is trying to find out whether it costs more to the hospital to let the employees live outside or to house them. Can anyone tell us their experience in this matter? It really has become a great problem with many of our institutions, where they are overcrowded and owing to building conditions cannot put up buildings and therefore have been compelled to have the employees live outside. Furthermore we have found that on account of the high cost of living, some hospitals have quit giving room and board to the employees, but pay them a flat rate and let them live outside, even get their laundry done outside, etc. Has anyone anything to say on this subject that will be of value?

A MEMBER: We have found that if the hospital owns its own property, it is much cheaper to house your help, because your property is exempt from taxation. If, however, you do not own the property, it costs you more money, of course.

A MEMBER: The custom of the U. S. Public Health Service is to furnish quarters for its employees wherever possible. When that cannot be done they give an allowance of \$30 to \$35 a month in lieu of that.

THE CHAIR: I think that answers the question very well for the member. That \$30 or \$35 a month, does that include room and board?

A MEMBER: That is simply for the room; that refers chiefly to the nurses and some other employees; single men, \$15.

MISS ROGERS: Does that mean civilian hospitals?



THE CHAIR: The U. S. Public Health Service.

MISS ROGERS: I was asking how much employees were paid in civilian hospitals who live outside of the hospitals?

A MEMBER: \$15 extra to room out.

THE CHAIR: That is about what they pay in Chicago.

DR. WILSON: That is what the city of New York established four years ago, \$15 for the room alone.

A MEMBER: The City Hospital of Detroit allows \$30 for room and washing and they have all their meals in the hospital.

A MEMBER: In the U. S. Public Health Service, if they do not have meals and laundering in the hospital, they are allowed \$62.50.

THE CHAIR: "Would it be practical to install a central gauze room for several hospitals in a community to standardize bandages?" Can anyone say anything on that subject? I do not think there is any question that a great deal could be saved by standardizing bandages. As to whether or not it would pay to have a central gauze room to do it, I am not in a position to say, but I do believe that with a small hospital that has not got the machinery and the space and the employees, etc., to make the bandages and has to buy them, it would be a very good thing if bandages were standardized. Some use five yard bandages, some ten, and some something else. It would be a great deal of money saved, if they were standardized. "What is a good method to employ for the identification of a newborn infant?"

MR. MORSE: Footprints.

THE CHAIR: Anyone else? Some use fingerprints. Can any superintendent of a maternity hospital give this member some idea how they mark their babies?

A MEMBER: We use an aluminum tag: baby and mother have the same number, and that is put on before the baby leaves the delivery room.

MISS MORRIS: We use a linen tag tied to the left wrist with the number and series and date born.

A MEMBER: St. Luke's, Cleveland, is using the footprint in addition.

A MEMBER: Last year we were thinking that footprints require experts and tags will wash out, so we started a system in the Brooklyn Hospital. Dr. Pomeroy originated a necklace so you can hook the baby's name right on it and you cannot break it. In the hook you put a shot and clinch it with a pair of pliers to hold it.

This is sent home with the baby. It is made by a Brooklyn concern and the complete outfit costs \$250.

THE CHAIR: To take up the financial question, "What are the charges in the maternity wards?"

(Several members replied respectively \$3.00, \$3.50 and \$6.00 per day.

THE CHAIR: I think the average runs about \$3.00 a day. "Are babies included in the charge, or are they extra?"

MR. MOSS: Extra.

THE CHAIR: This is really an important question, because there are so many superintendents in the country who are undecided whether they should charge for the care of the baby after it is born, or should not. The result is that part of them are charging and most of them not. The fact is that it costs nearly as much to take care of a newborn baby as it does the mother, and I do not see any reason why the hospital should take care of the baby for nothing if the family is able to pay for it.

MR. FOWLER: At Poughkeepsie we charge \$1.00 a day for infants that are fed artificially; private room patients, 50c a day for bottle fed babies, or 75c I think it is now; in the wards, nothing. The maximum charge in the wards is \$2.00, and from that to nothing. It is supposed to be charity in the wards and no charge is made for the infants.

THE CHAIR: You are losing money on the laundry work alone.

MR. FOWLER: Yes, and exercising a little charity.

THE CHAIR: I would like those who are charging for newborn babies to raise their hands.

A MEMBER: Ward or private?

THE CHAIR: Both. Those that are not making charge. I see the majority are not making a charge for babies. I would suggest to you that when you get home you look into this matter carefully, because there is a chance for increased revenue to make up a deficit that probably this member who wanted to know how we can provide for a deficit might take note of. "Should a patient be sued for non-payment of hospital accounts?" One member says, "Why not?" Another says he does not think so. Another says, "Sue him after thirty days."

MR. BORDEN: As I understand the relation, it is this; when the patient comes, you first find out how much he can pay; you then make an agreement as to what he

shall pay; then you send him, in due course, his bill. He does not pay. You send him his bill again; perhaps you send it to him a third time. Then you put the matter in the hands of a collector, the only reason for that being that the collector has more time for personal interviews than your office. Then it comes into the hands of a lawyer. The first thing the lawyer will ask is whether the party has any property. If he has property, the lawyer will advise you to begin an attachment, and after that comes the question whether you shall bring the case for trial or not. When you get to that point, you either find out that the man has no money, or he has a grievance or thinks he has a grievance. If he has no money, it is no use to proceed any further. If he has a real grievance, better drop it. If he thinks he has got a grievance, every bad story is believed by some people, and, as a rule, it is better to let the matter go before you bring it to trial.

There are always exceptions. (Applause.)

A MEMBER: I think the best plan is to collect the bill before the patient leaves the hospital. (Laughter.)

DR. WILSON: The hospital, with regard to its bill, wants to stand in the same relation to the patient that the hotels do, and ought to have the same sort of legislation, and personally I think that this Association should go on record to that effect. (Applause.)

THE CHAIR: We will get such legislation when we have organized hospital associations in each state. "Should a hospital be managed so as to avoid a deficit?" (Laughter.) There is a great difference of opinion on this by some of our boards of managers. Some boards of managers claim that if you want to get money, you can do so if you have a deficit. Others claim that you cannot go out and get the people to pay for a dead horse. Are there any hospitals that are operating without a deficit? Those that are hold up your hands. About twenty. Those that are not. You have the majority. I think it must be the proper thing to run a hospital with a deficit; the majority of you do it. "Should not hospital employees be given increases in proportion to the increased cost of living and how are these increased costs of living to be met?" I think that every hospital in the country has tried to increase the salaries of employees in proportion to the cost of living, so far as they have been able to do so. The expression that was given here of the wages paid would indicate that pre-war prices were

less than half of what we are paying now. "What is the advisability of charging all staff members a percentage of their fees collected from private patients?" (Laughter.) I know of some hospitals where the boards of managers have been thinking seriously on this subject, and they feel that inasmuch as they furnish the equipment, the gloves, the suture material and everything for the doctor to work with, that he should pay a percentage of his fees into the hospital.

A MEMBER: In addition to the charge to the patient?

THE CHAIR: Yes; in addition to the patient's charges, that comes out of the doctor's fees.

A MEMBER: I think we lose our perspective in that respect. It is not the doctor who is supplying all those things; it is the patient, and I do not think we should make the doctor feel that it is for his particular benefit, but it is primarily for the patient. I think it would cause a great deal of trouble with the profession and we want to always keep in as good an accord with the profession as possible.

MR. CLARK: Does not that simply mean a new way of collecting hospital bills? Hospital bills will not be so great and the surgeon or physician will make his a little larger. The patient has to pay it. I do not see any real point to it. There might be some point in collecting the fee from the physician or surgeon when you go out of your way to help him. He is helping you when he says that that patient has the money in his pocket to pay the regular hospital bill. I think it is a matter of mutual assistance.

MR. MORSE: I believe it would be disastrous to do a thing of that sort. That is the very thing the American College of Surgeons have been fighting for years under the head of fee-splitting.

MISS SAFFEIR: Where the doctors give so much of their time gratis to city patients, shall we charge them something because they bring their patients to us? I think it would be rather peculiar.

THE CHAIR: I think if we charged the doctors a percentage on the money they collected from the patients, they would not want to give us free work any more.

MISS SAFFEIR: No, I think not.

A MEMBER: I agree with the lady, it would be a boomerang. That may have to come some day, but it would only hasten it.

THE CHAIR: I have talked to a good many superin-

tendents on this subject, and it is the concensus of opinion that it would be disastrous.

DR. BISHOP: I do not think that the system would work in an open hospital, but in a closed or semi-closed hospital, it would work beautifully. The surgeon pays the hospital, collects all fees and pays the hospital a quarter, and they are more interested than we are in seeing that the bills are paid.

MR. MORSE: If Dr. Winford Smith or Dr. Seem is here, perhaps they would tell us something about the plan in operation at Johns Hopkins. No response.

THE CHAIR: You might bring this subject up again tonight. "Can a 100 bed hospital, properly managed, pay a fair rate of interest on the investment? If not, why not?" If Dr. Hornsby was here, he could answer that question. I will say there is no reason that I can see, why a hospital should not pay a fair rate of interest on the investment if they do no charity work, the same as a hotel does, or any other business, but I do not believe it is possible for a hospital to pay any rate of interest to amount to anything on the investment if they do over ten per cent charity work. They might be able to pay a small rate on a 10 per cent charity basis in some sections of the country, but not in all sections. Has anyone anything to say on this subject? Evidently this question is important to the person who asked it because he was expecting to build a hospital by raising money through the selling of bonds, and was looking for information. "To what extent should a hospital do free work?"

MR. FOWLER: In regard to that, I would like to ask how many hospitals here do absolutely free work for patients? A great many hospitals get most of their so-called charity patients paid for by town or municipalities. Some hospitals get no pay from the public at all. The hospital I represent gets no pay from municipalities or towns.

THE CHAIR: I would like to know how many do get charity patients paid for by the municipality? The vote shows that there's very few that do.

A MEMBER: The city pays us so much per patient, the ward rates for all patients they should pay for; they do not give us any allowance. We have some free beds where they take care of the patients free of charge who are not obliged to be taken care of by the city.

THE CHAIR: "What are the advantages of a system of bookkeeping that will show the expense of operating each

department?" If anyone is keeping books so that they can show the expense of operating each department, will they tell us something about it for the benefit of this member?

MR. MORSE: It is very instructive but very expensive.

THE CHAIR: That is what I have found out too.

A MEMBER: We have had it for one year only, and it showed us that not a patient in our maternity department, even in our most expensive private rooms, had paid their actual cost in the past year. We have the average cost for our ward patients, our private patients, our maternity departments, for the social service and operating department. It is expensive if put in the hands of an expert accountant to determine. We make out a basis that the cost of this department is a certain percentage of this, that and the other. It is a very complicated table, but we think it pays; we raised our rates 30 per cent after it. (Laughter.)

THE CHAIR: Has anyone else anything to say on the subject? If not, we will take up Construction. I am going to ask Dr. Moss to take the Chair.

DR. MOSS TAKES THE CHAIR.

THE CHAIR: "Should the nurses' home have direct connection with the hospital, or be remote?" I presume the writer meant removed.

MR. CLARK: On the same grounds, but not connected.

MR. FOWLER: A few years ago I visited a hospital in the state of Connecticut, and they had recently erected a covered passageway from their hospital to the nurses' home, and the lady superintendent assured me that it made the greatest difference in the matter of the illness of their nurses since that covered passageway had been put up; there was much less illness among the nurses due to catching cold, etc. It has that advantage, undoubtedly, but on the other hand it is a good idea to get the nurses as far away as possible from the activities of the hospital when they are off duty.

A MEMBER: Speaking from personal experiences with nurses' homes in the hospital and remote from the hospital, on the same grounds, but still, for all practical purposes, remote, I would say that in my experience, the morale of the nurses and the general morale of the patients, the general conduct of the hospital, was very much in favor of the nurses' home being out from under the hospital's roof. Personally I would be in favor of getting it as far away as possible and still allow nurses



to report promptly for duty without serious inconvenience for themselves.

A MEMBER: I would like to say something of our nurses' home. We have one of the finest in Philadelphia, and the connection with the hospital is made over a driveway. A room about 16 feet square was used as a solarium. I do not know that there is any part of the nurses' home that the nurses enjoy as much as they do that solarium. In pleasant weather we lock the door and make them go outside and get the fresh air. That room, 16 by 16, is very pleasant and of great value, and the nurses enjoy it.

THE CHAIR: "In the disposal of waste, what part does the incinerator play and which is preferable, a central plant or an individual incinerator?" The question is, the central plant versus the individual incinerator.

DR. WILSON: I do not know exactly what is meant by the individual incinerator, unless it is that little gas-burning affair you saw up at the Royal Victoria yesterday for burning up rubbish, such as the sweeping from the private rooms, etc. We placed some of those in our hospitals four or five years ago, but recently do not use them. I should say that the central incinerator is the better thing, but in some instances these little things get away with light rubbish that burns up quickly and easily and that is all they are good for and nothing else.

MR. CLARK: We had a practical experience with them in the General Hospital at Wheeling. One of the members of the Board paid for the placing of an incinerator in every service room in the house, as an experiment. We could not find if there was any hospital that had really tried it out. The incinerators worked; there was not any trouble about that, but all were finally given up except that one in the operating room. The one in the operating room for the disposal of pus dressings from the pus operating room, so-called, is continued, but the others were discontinued, because, in spite of all we could do, the pupil nurses, the special nurses in particular, disposed of material for which you could not account any other way. I think they are a nuisance on the floor, but you should have a central incinerating plant and perhaps one in your contagious quarters and in the operating room.

A MEMBER: The incinerating plant could be connected with the main heating system so it could be utilized for the burning of the garbage.

THE CHAIR: I believe that is a very important point. Is there any other discussion?

MR. ASA BACON: One of the principal reasons for having a central incinerating plant is that the man who takes care of the garbage, etc., can sort it out and save a great many hundred dollars a year to the institution in silverware, surgical instruments and the thousand and one things that get down to the garbage room through the carelessness of employees, nurses, etc. One hospital superintendent told me that he felt that he saved the salary of a good man to look after the incinerator room through the saving of instruments, silverware, etc., that he found after sorting the garbage.

A MEMBER: I have had considerable experience with incinerators for different purposes. The incinerator for the soiled bandages, etc., will work very well wherever you put it. I am rather inclined, however, to think they are nuisances when scattered around, as another speaker has said. The small incinerator for garbage that they try to sell so many hospitals and have succeeded in buncoing most of you into buying, is not worth anything, for this reason: the heat generated in these incinerators will cause a fusion of your grate bars with knives, forks and things like that, and very quickly your grate bars are gone. They try to tell you that it is very economical and that you can run an incinerator for about twelve or fourteen dollars a month, an ordinary type, of medium size. Now I put a gas meter on it and that incinerator cost me \$35 to \$47 a month. When you put the gas meter on, you will find out what it cost. They will tell you also that you can cook with a gas range much cheaper than with coal, and all that kind of nonsense, but when you put that gas meter in, it is not so; and then they always tell you that you haven't run it right. The only incinerator that is worth while is the fire brick-lined incinerator, and you are wasting your money when you spend it for another type, except for the purpose I have stated, and even then, if you get surgical instruments in your incinerator, it will fuse your grate bars and you will be buying new bars all the time. Another thing—by all means have the incinerator inside your building. I seriously object to carrying the garbage outside. If they carry it outside, they will spill it, and you are putting the flies on the trail of how to get in. A fly is a very clever chap. If there is a way to get in, he is going to find it and you will have him getting in when-

ever screen doors are propped open to carry out the garbage. Burn your garbage inside your building near the kitchen and you will not have flies, and by all means do not let wagons come for the garbage if you can help it, because, if you will take the pains, as I have done, to demonstrate to a number of people that the flies come in with the garbage wagon—they follow it up in great flocks, and when they get to your hospital they say, "Boys, all off for breakfast," you will find that is why you have flies around your building. If you will burn your own garbage, you will hardly have a fly, but the minute we began burning our garbage over at the engine plant, we began to have flies.

THE CHAIR: The next question is, "What is the best size of rooms for patients, small, medium or large?"

MR. BACON: For the benefit of the member who asked that question—and, by the way, it was one of our men from the Middle West, where the problem of supplying patients with a small, cheap private room, is very great—I have had a drawing made of a *minimum*-sized private room, as a suggestion to this member or any member contemplating building a hospital. The drawing is here on the screen, and after the meeting it will be explained to anybody who is interested. The room is 8 ft. 6 in. by 10 ft. 6 in., a minimum size.

MR. W. S. NASH, of Tennessee: Did the Doctor contemplate the keeping of a special nurse and patient in a room of that size?

MR. BACON: You can if you wish. It is only a question of ventilation.

MR. NASH: Did he figure out—

THE CHAIR: Mr. Bacon said it was all figured out.

MR. NASH: Surely he did not take the number of cubic feet of air in consideration?

THE CHAIR: What would constitute a medium sized room? Can we have any opinion on this question?

THE CHAIR: I suppose if we know the minimum, we can easily estimate the others. How many rooms with baths should there be?

MR. NASH: One-half the total number.

MR. FOWLER: I asked that question because I am interested in getting some in the hospital. I would like to know what is the maximum size, the limit of size that they should not exceed.

THE CHAIR: The maximum size.

A MEMBER: I find the 13 foot square room advisable,

because it is necessary that, in an emergency, it should be able to hold two beds comfortably.

A MEMBER: It seems to me the size of the room may depend somewhat on the frequency with which you change the air. If you have a small room, you would have to have forced ventilation. A room which is 10 by 13 feet is a fair sized room. In regard to a bath room, I know that we think of a building, a new pavilion, as having every third room devoted to a bath and toilet, so that it gives every two patients a private bath and makes them use the bath freely, and each room has a private toilet. I think the toilets are very desirable. I do not think the bathtub is so necessary, though if you can afford to do it and charge your patient enough to pay for it, that is all right. I think one private suite with a bath for every ten patients would be a fair allowance.

THE CHAIR: "Should windows come down to the floor or just ordinary windows?" That is an interesting subject. We would like to have some expressions of opinion.

MR. BACON: It depends on the section of the country where you are building.

THE CHAIR: Yes, that would depend on the location.

MR. NASH: If it is in the extreme South, windows should come down to the floor and be copper screened so that you could pass out on the veranda; it makes it much more comfortable to the patient and the patients will stay longer than where they are crowded into rooms.

THE CHAIR: "Would you have doors that swing free, or ones that will lock?"

DR. WILSON: Recently an architect has made a suggestion that the building we contemplate should have all the doors slide into the wall, and I believe that that suggestion has a good deal of commonsense in it. I think it would be well to consider it.

A MEMBER: You want to beware of the suggestions of an architect unless you have tried out his plan. (Laughter.)

THE CHAIR: That is a very good suggestion. Mr. Clark, how are you planning your new hospital?

MR. CLARK: It will have double swinging doors.

THE CHAIR: They may be locked?

MR. CLARK: Yes, a deadlatch.

THE CHAIR: "Should a sterilizing room be connected directly with the operating room?"

A MEMBER: It should not be, because the steam from the sterilizing room will spoil the instruments.

MR. BACON: It not only affects the instruments, but it creates a condensation on the walls that is very difficult to overcome.

MR. CLARK: The ventilation should be from the operating room out, then you do not get the steam in the operating room.

DR. WALSH: I think there should be a connection between the two, and I am so advising now in construction.

THE CHAIR: "Have any experiments been made in color therapy, in painting walls of hospital rooms and wards?" That is a new subject. Mr. Bacon, have you experimented with the various colored paints for private rooms and wards?

MR. BACON: Yes, I have, a great deal. I find that a soft gray or a mild buff are about the best colors for the patients in a hospital.

DR. WILSON: I tried to stop the pitting of smallpox by using red window panes once. (Laughter.)

MR. BACON: Did it work?

DR. WILSON: It did not. I told this story once and am ashamed to tell it again. The only effect it had was this: (This is a fact, and I think it might be well for the members of the Association to profit by the mistakes of other people sometimes) the red shades we had in addition to the red window panes had such an effect that it was not very long until the nurses and doctors and patients were all at variance and were quarreling all the time; in fact, everybody was seeing red; I imagine they could see blood under ordinary circumstances.

On motion the Round Table took recess until 8 P.M., at which time Treasurer Bacon called the meeting to order and the program was resumed as follows, Mr. Bacon being in the Chair:

THE CHAIR: As I said this afternoon, this is a get-together meeting, and it is entirely in your hands to discuss the various problems fully and freely. In order to get these questions properly answered, I am very anxious for everyone here tonight to have some voice in this meeting, the ladies as well as the gentlemen. The complexities of administering a hospital are many; therefore we have a long list of questions. If they are not all answered here tonight, I wish to say for the benefit of those who were not here this afternoon, that we have an Advisory Committee that will be glad to meet at nine o'clock tomorrow morning, to discuss any problem with

you and try to help you to solve it. The names of that committee are on your program.

MR. DANIEL TEST: May I say just one word before you begin on this, and that is in reference to answering these questions. I am sure that we perhaps all feel that some questions are foolish. I must say I thought so this afternoon, and I have gotten up to speak because I realize that I was quite unfair. The question was one that was very important to the one who asked it, and that is what we are here for, to be patient with each other and to give more than we receive, and I only wanted to say that, so that I will not be as inconsiderate or as impatient as perhaps I was this afternoon. (Applause.)

THE CHAIR: We will forgive you, Mr. Test. It is a fact that some of these questions appear very simple to some of us. As I was telling Mr. Test before the meeting, this question that came up this afternoon, about the amount of soap powder, etc., that is used per bed per patient; some thought that was rather a foolish question to ask: Now the superintendent who sent that question has a small hospital of about 75 beds, with a board that is composed mostly of women who are around the hospital a good part of the time to see what mistakes the superintendent is making, and they were complaining to her about using so much soap. It was soap, soap all the time. She got tired of it and wrote to me and wanted to know if I could find out how much it cost per bed per day for soap and powder, so that she would have some data to take to her board and settle the question. Now you can see that that question was highly important to that superintendent and she is going to settle it. The matter of the care of mattresses and pillows is another; I simply mention these two as illustrations. The superintendent who asked that question has one or two medical men who insist that the mattresses be put in the autoclave and sterilized. Now you and I know what would happen to those mattresses, and she has tried to persuade those men that it would ruin the mattresses. She wanted something from this convention that she could take to those Doctors and show them that to put mattresses in an autoclave and sterilize them is not the proper thing to do; and that is so with a great many of these questions; so we must be patient and try and answer them. For that reason I want to have the cooperation of everybody in this room tonight because



the questions are vital to the people who asked them, and if we cannot settle them here, I do not know in what part of the convention we can. The first question to-night is "Should doctors be charged with articles destroyed, namely, syringes and things of equal value? Should a surgeon operating on private patients be required to furnish his own sutures when he demands other grades than those in the hospital stock?" Has anybody anything to say on this subject? Do any of you make the doctors pay for suture material and the syringes they break and other things they destroy in the operating room? (A number shook their heads.) Evidently you do not. I think some of you do make the nurses pay for them, don't you? (A number nodded affirmatively.)

MR. WALTER PILGRIM: In one hospital with which I was connected, it was the custom of the doctors to request all sorts and conditions of things. It became very irksome. A committee of the medical brotherhood was requested to furnish a list of the standard supplies for that operating room, and any deviation from that list was to be furnished at their own expense.

MR. SCOTT: I presume I would charge an occasional operator for breakage, but not a man who worked there every day.

THE CHAIR: You would not charge for breakage, the regular members of the staff?

MR. SCOTT: I would not.

THE CHAIR: But a man who came there occasionally and broke something, you would charge him for it?

MR. SCOTT: Yes, that is the rule we have.

THE CHAIR: This question ought to bring some fire: "What qualification does a medical man possess over that of a graduate nurse, for a position as superintendent of a hospital, both having equal business qualifications?" (Applause and laughter.)

MR. PILGRIM: I move that the question be laid on the table. (Laughter.)

THE CHAIR: In the Round Table session, nothing is laid on the table. It has to be settled one way or the other.

MR. DREW: I do not think the medical man has any advantage over a graduate nurse whose business experience is equal. (Applause.)

MR. SCOTT: I vote in favor of the nurse every time. (Applause.) We have tried this personally and failed, and I will admit there is no doctor capable of doing the

nurse. I do not mean to say a nurse who is just fresh from school, but when it comes to this type of positions, a qualified nurse is as good as any man.

A MEMBER: I think something should be said as to the size of the institution. I believe the answer to the question is entirely different, depending altogether on the size of the institution.

MISS SAFFEIR: I would like to know why the size would make any difference? A small hospital is far harder to operate than a larger hospital. I am talking seriously. In a small hospital you have to be everything; a great many times the superintendent is cook and has to do it; in a larger hospital we can afford to have competent heads of the departments and all we have to do is to get the reports from the heads of departments and see that they work right. Dr. Parnall last night made the remark that he thought a woman should not be a superintendent because most men do not like to work under women. As far as that is concerned, a woman who has any tact and can be superintendent of a hospital, knows how to deal with men working under her; she does not assert herself because she has authority if she knows how to deal with them; provided she is the right woman, I do not see why a hospital of 500 beds or a hospital of 50 beds should make any difference, if she has ability and training, whether man or woman, either one ought to make a good superintendent. That is my experience. (Applause.)

DR. C. G. PARNALL: I foresee that the evening is not going to be long enough to settle this point. As a matter of fact I did say that I thought a man who was a medical man was better qualified for the position as the executive head of a hospital, but I do not think I would make any distinction between the small and large hospital so far as a woman is concerned. I hope that my point was clear. I stated that the reason that women, especially trained nurses, are very largely employed, was because more intelligence could be purchased for the money in the case of the trained nurse than in the case of the doctor who was properly qualified. As I said in my paper, not all doctors are qualified to be hospital executives; far from it. I hoped that discussion might follow my paper, but I advise you, who are not medical people, not to go home and resign. The point I want to make is this; perhaps the times will change, but men are rather loath to take directions from women. Now that

is the practical point; that is the experience of every one of you, I have no doubt, as most doctors are men and as a considerable number of employes are men, you can see why I feel that the position as executive head of the hospital should be vested in a man. I also make the statement that I believe the executive head of a hospital should be a medical man. I realize that some of the best managed hospitals in this country, are run by laymen. A good layman, as far as the management of a hospital is concerned, is far to be preferred to a poor doctor, and perhaps there are as many good laymen in the management of hospitals as there are doctors. The point I want to bring home is this, that medical men should be specially trained. They are not now specially trained. Until that time comes, of course we have got to do the best with the personnel that is available, and the layman (and the nurse in this sense is a layman) is handicapped when it comes to dealing with medical men. Members of the medical staffs, whether they be connected with small hospitals or large hospitals, have about the same degree of mulishness, and they resent suggestions from any but medical people, and I believe that only a medical man really is competent independently to pass judgment, and that was the reason for the statement I made.

THE CHAIR: Has anyone else anything to say on this subject?

DR. WILSON: I happen to be the superintendent of a contagious disease hospital. It is my duty to see that the cases in this hospital are sorted out right. Of course, there are men employed to do that sorting, but believe me I would be very uneasy if I did not have the medical knowledge that goes along with the sorting, so that in certain essential instances unquestionably a medical officer at the head of the institution is much better than a lay officer. I want you to understand that I say a medical officer, because some of the best medical superintendents I have known have been women. The business of a hospital is the cure of the sick, and the advantage of having a medical education on the part of the executive officer, must accrue to the advantage of the patient. The greatest thing about it is the satisfaction that the executive officer gets from the knowledge that he knows that his subordinates have been trained in that particular line of work.

MR. LODER: Medical professional men and women, as we know, and laymen and laywomen, as we know, have

served as superintendents of hospitals. Now at this meeting it has been repeatedly contended the superintendent should be a man and others have argued that the superintendent should be a woman, and it has been contended both ways as to the superintendent being a layman or a professional man. Now I have seen men and women in all those classes succeed and fail. I think it is time that we face the fact that it does not depend on any one group or class, and that we will never reach the time when any one group or any one of these classes will be able to handle, in the most effective way, the hospitals of our country. There are some hospitals into which a woman, either a nurse or a laywoman is most fittable; in other cases a man is needed. I know hospitals, and you may know some too, where a woman would be unable to fill the requirements, and it is the same as to men being able to serve in other hospitals. There are times, though, I think, in nearly all our hospitals, either of large or small bed capacity, when whoever is in charge may wish that there was someone there of the other sex and I know of cases where I believe it would be a splendid thing if the woman superintendent could have had some man convenient to help her in dealing with some of the labor problems or other contests that come up where the male help have to be handled or where problems come up in connection with the orderly, his conduct or his plans, and other things like that; but I would like to say this, finally, that I think we should all settle, once and for all, that each hospital has peculiar requirements of its own, and what we want is a person who can handle that job irrespective as to which group or class under which they may come. (Applause.)

THE CHAIR: We will go a step further; I have another question that says "What is the objection to business women being executives of hospitals?" Some of them think that if business laymen can be superintendents of hospitals, why cannot business women with proper business training, etc., be superintendents of hospitals? Does anyone care to say anything on that subject?

MR. FOWLER: This perhaps is not quite germane to the question, but I think it throws a little light on the situation; an intimate friend of mine, who had a very large and successful business, told me that he had, at the head of his accounting department, a woman, and that the department had never been so successfully or well run as under that administration. That business

was sold out not long ago for about \$5,000,000 so you can imagine the magnitude of the business that was involved. I quite agree with Mr. Loder in his idea that different situations call for different kinds of administration, and there are many hospitals that undoubtedly would be much more successfully administered by a woman than by a man. On the other hand, there are many institutions that need a man of certain experience and qualifications. To be a little personal, I have, for 35 years of my life, been a practicing lawyer, and the question came up with reference to my taking the administration of an institution. I hesitated naturally about doing so, but I felt that that particular institution at that particular time required certain things, which I felt that I possessed, and I am sure that to some extent my judgement was correct; so I do not think that we can say that, as a general proposition, a woman would make a better superintendent, a business woman or a nurse, or a man, a business man, or a doctor. New situations require new solutions.

THE CHAIR: We will take up the next question; "Should a Church hospital which is doing a large amount of charity work, with profit from pay patients, be expected by the Board of Trustees to pay off its bonded indebtedness with the income from patients?" (Laughter.)

MR. PILGRIM: As a business policy of the Board of Trustees, I should say that they had a perfect right to do as they wanted with the profits accruing from the patients, but if the superintendent was sensible, he would see that there was very little profit at the end of the year. (Laughter.)

THE CHAIR: If he worked out his budget carefully, he would not have anything left, would he. (Laughter.) Now I have one more question on the nursing subject. "Should Pupil Nurses, during their second and third years' training, be used as specials in the hospitals?" (A number of members shook their heads in the negative.) I think the quickest and best way to settle this is to ask those who think they should be used as specials during the second and third years, to hold up their hands. Now those who think they should not. (A large majority responded in the negative.)

A MEMBER: I think it might make a difference if there were any charge made for the use of the pupil.

THE CHAIR: I think so, too. It does not say anything about that.

MR. LODER: In several different hospitals, where they



have taken the student nurses of the second and third year and put them on private duty, or special work, they have charged the patient \$3.50 per day plus the regular board, for a private nurse, and then allowed the nurse 50c a day additional. These institutions following that plan have tried to secure extra nurses for their training school and they have thus been able, in some cases, to entirely handle their own matters with their own special nurses without using nurses from the outside. Now I know that there is a difference of opinion on this plan, and I have a question in my own mind as to its desirability in some institutions, but I have seen it worked, especially in Kansas, Texas and Missouri, this last year, and have seen it work well, and I know of one hospital that was able to entirely eliminate the special graduate nurse from the outside and use their own nurses, and in a manner, that eliminates all the trouble that you and everybody else has with special nurses who intermingle with the student nurses.

A MEMBER: This practice would commercialize the nurses and their training, but there are two instances where it might be allowed; first, a very sick patient who could not afford to pay for service, to have the special service free; the second would be that our nurses in training ought to have a little time especially before they graduate to learn the art of the special nurse. I would think that would be the answer to this question.

DR. WALLENBERG: This question was one that was very prominent in San Francisco a few years ago, and resulted in the eight hour law, which prohibits this practice in California. A hospital run by a group of doctors was in the habit of putting pupil nurses as specials on cases, charging the patients \$5 a day, and allowing the nurses nothing, and even putting these pupil nurses on 24 hour shifts. It was very profitable to this group of physicians; they made a great deal of money out of it, but they are now restricted by the California law from any such practices. Pupil nurses can be put on as specials, but they cannot charge a patient for the service of a pupil nurse. It was generally abused in California prior to the passage of this law.

MISS McMILLAN: This last summer in the school where I am, the third year pupils were allowed to select a special nursing course, and one of them was nursing ten hours a day. There were only two young women in the entire school so far, who have selected special



duty nursing in the third year. A great many have selected other work, and it would seem that our student body should be given an opportunity to select that work in their last year just as they would select public health nursing or some other definite specialty.

MR. JACOBS: I would like to ask Dr. Wallenberg, of San Francisco, if that law would prohibit the assignment of a pupil nurse to the care of a patient in a municipal institution?

DR. WALLENBERG: We are restricted from working a pupil nurse over eight hours, and no hospital can charge a patient for the services of a pupil nurse. A pupil nurse could be assigned to the care of a patient, they could not collect for that service.

MR. BORDEN: We put our nurses on special duty. We think it is a very important thing to do, because, in the first place, we undertake to give all necessary nursing service to people who pay the hospital rates, and that means that in critical cases a nurse should be appointed especially to take care of that patient during a critical period, and we also think it is a very important function for the nurse, as she approaches graduation, to have experience in that form of critical cases. We differentiate between that and what we call private nursing, and if a patient desires to have a private nurse, then that patient must secure a graduate nurse and pay the graduate nurse the salary to which she is entitled. (Applause.)

DR. DREW: I do not think it fair to take a student nurse away from a ward patient to care for a private patient, but in the hospital where I am, almost every day we have a ward patient so sick that nurses are assigned to that patient during the critical period. We do not make any charge to the patient. They get quite a good deal of experience as specials in that way, but when the patient pays for a special nurse, they ought to have the advantage of a graduate nurse.

THE CHAIR: We will take up the next question, one that was handed me this evening, of a mechanical nature; "What is the experience of electricity for heating and cooking? When should electricity be purchased and when manufactured?" Can any of you say anything on the subject of using electricity for heating and cooking?

DR. DREW: Electricity is very convenient for cooking, but it is rather expensive, and the heating parts of

an electric stove burn out readily. There is nothing so convenient for night dressings and the small work which we put these little electric stoves to, and we find them very satisfactory, but I do not think it is very satisfactory for extensive cooking, although I know that the company has put on the market stoves which they claim will do all that a gas stove or a coal stove will do, but the heating units burn out very quickly.

THE CHAIR: Has anyone else had any experience with cooking by electricity?

DR. WALLENBERG: With regard to the purchase of electricity, it seems to me that if you have a heating system that produces exhaust steam and can produce electricity as a byproduct, it should be developed in the institution. The electrical company of California wanted to supply "The Relief Home" with electricity. They had a survey made by experts outside of their company who reported that our development of electricity was entirely a by-product of the heating plant and cost us nothing.

MR. SWERN: I think the question is one that depends greatly on the size of the hospital. That is, a small hospital cannot very conveniently generate their own juice and make it at the same rate they can buy it from the public utility company. The larger hospital of over 500 beds, can undoubtedly generate their own power and electricity at a smaller rate than you can buy it. For a small building, I think you should stick to buying it from a public utility.

THE CHAIR: Any one else? This side of the house is not talking tonight. Do any of these ladies use electric stoves for cooking in their hospitals? No response. We will take up the next question. "Is the Community Chest plan a solution for fund raising for the charity work of hospitals?" That was discussed at one of our other sessions, but evidently this question should be discussed a little further. A great many are not satisfied that the community chest plan is a solution for fund raising.

DR. MOSS: This question arose this afternoon when we had an informal discussion between Mr. Pliny Clark, Mr. Bacon and myself. I contended that the development of the Community Chest or so-called Federation of Charities during the past few years throughout the country has, in a way, interfered with the progress of the individual institution; that the Community Chest or Federation has taken the very spirit and heart out of the

institutions themselves; that they have organized themselves into a so-called trust; that the institutions are handicapped in their work, inasmuch as they have obligated themselves not to appear before the public for the collection of funds for the needs of their institution. In most communities the so-called Federations act as collecting agencies for all the charitable organizations throughout the city, and thereby the individual institutions, who formerly were privileged to go to the community and ask for contributions and funds of various kinds are definitely handicapped in their work. I can name several important institutions, hospitals in particular, who in the past two or three years, have gone under the wings of the community chest and have fared far worse than in the past. Whereas, formerly, they had their own contributing membership, had their own so-called drives and campaigns, today they definitely cannot undertake any such venture without the consent of the central organization, and today these very same institutions have to work under a restricted budget, not receiving sufficient funds to meet their daily need. The most important part of this particular work is the fact that the institutions have more or less lost their individuality. You know when a hospital goes out in a community, whether large or small, for the purpose of obtaining money for any special building fund or any maintenance, there is a certain amount of publicity connected therewith; the community is informed of the work the institution is doing and they are alive to the progress of that particular institution. Under the community chest plan the individual institutions are subordinated to the large body, and as a result, it seems to me that there is a lack of spirit and interest on the part of the citizens in the communities, that the contributors are rather interested in the pure cold business proposition, and that is to contribute their annual donations to the large body, forgetting their subsidiary institutions. Of course it is a more modern method of connecting the institutions; it is perhaps, from a business point of view, the most ideal; but I have a personal feeling, in view of my experience with several institutions in the past four or five years who have gone into these so-called Federations, that the institutions are far worse off than they were before the consolidation under the central body.

THE CHAIR: Is there any further discussion on this subject?

MISS KEITH: I do not like to hear that subject broached with only the objection to the community chest. Rochester has had a community chest for three years, and I have yet to hear any objection or any adverse criticism from any one of the thirty or forty institutions which participate in it. In our case each institution is asked to submit its budget for the coming year, its estimated income and its estimated expenses. The budget committee of the community chest are a pretty shrewd lot. They look over this budget and cut down. Last year our budget was cut down about 25 per cent, I think, but we are drawing from the community chest this year \$128,000, and there has been no time in the history of the hospital when we have been able to solicit and obtain anything near \$128,000; it will take care of about a third of our expenses this year. The weak point, to my mind, is that it only provides for maintenance expense. It does not provide for construction, for additions and how that is to be met in the future, I do not know, but during the years of the war and this present year, it has been a great comfort to us to have the community chest. The minor dissatisfaction with it was among a great many small contributors who were contributing for the first time in their lives to any public object, and some of them feel that they have a sort of first mortgage on the institution and are ready to tell us how it should be run, but that objection is small compared with the advantage of being sure you are going to have a check for a certain amount on the first day of every month, and you know what you have and what you can do. I personally am very much in favor of it.

THE CHAIR: Is there any further discussion of this subject? If not, we will pass to the next question. Before doing so, a member handed me this slip stating that electric heating appliances are very convenient but always out of order and require skilled people for repair. The next question is, "Is it desirable that all visitors to the hospital pass through the social service department and that all bureaus of information be conducted by this department?" Are there any social service workers here tonight? If so they don't have very much to say.

A MEMBER: I suggest that if Dr. Haywood is in the audience he be asked to speak on that.

THE CHAIR: Is Dr. Haywood in the room? I do not see him. Has anyone anything to say on this subject?

DR. MOSS: This question comes up quite frequently

in most hospitals as to whether it is fair and just to prohibit visiting by the wage earner of the family. In Massachusetts, as they cannot come during the regular visiting hours, which are usually in the afternoon, we have established two visiting evenings during the week, 7 to 7:30, with the understanding that it is only for the wage earner and that has met with such great favor that I believe it is a very good thing for every hospital to adopt.

THE CHAIR: The next question; "What should be the attitude towards the press?" That was answered last year. If the member will refer to last year's proceedings, he will find a very complete answer to that. "What means do you find best adapted to advertise the hospital and its needs?" That also was answered last year. "When only one record clerk is employed, how to provide for emergency, such as illness?" I suggest that the superintendent will have to do the relieving in a case like that. "How best to communicate rates, rules, etc., to patients? If so, when?" I might say for the benefit of that superintendent that in the Presbyterian Hospital, when a patient is admitted, a little card that folds into a little booklet form, is handed to the patient telling him what the rates of his room is per day, what the rules of the hospital are, and that he will be charged extra for X-ray, special laboratory work, operating room, etc. If it is an emergency case, this card is handed to whichever member of the family or friend gives the information at the admission desk. If the superintendent who asked this question will write me, I will be glad to send a copy of this card. "How many women superintendents are present at the business and executive meetings of their boards? Is their attendance desirable or not?" Now if there are any trustees in the room, we would like to hear from them.

MR. BORDEN: I am a trustee and I have answered that question a good many times. I do not see what business a business organization has to do business unless the person who knows about the business is there to talk business. (Applause and laughter.)

A MEMBER: I am a trustee and I agree with Mr. Borden fully.

THE CHAIR: Anyone else? This is rather an important question, because I know a great many women superintendents who are not invited to attend the business sessions of their boards. There are also a good many

of the men superintendents that are not invited. "How can a small rural hospital develop a health centre?" That was very well brought out by our friend from Iowa, I think. "How to prevent petty thieving of alcohol?"

DR. HOWLAND: I was talking with a superintendent who had had a great deal of trouble with the loss of alcohol. After consulting his chemist, he added tartar emetic, a poisonous rose, to all alcohol, putting that label on the bottle, and he said that he doesn't lose any alcohol now. (Laughter.)

THE CHAIR: I think that answers the question. That is about the only way we can stop it. "How do you keep a record of alcohol distributed? Oklahoma requires that it be done." I do not know of any other state that does require it.

A MEMBER: Massachusetts requires it.

THE CHAIR: Will some of you who have to keep a record explain it so that this superintendent will know how to do it?

MISS AYRES: In the State of New Jersey we are required to send in monthly a statement of the amount of alcohol and all liquors used during the month. The drug clerk is obliged to keep a record. As he draws the alcohol from the barrel it is denatured, then he is obliged to keep a record of the various wards, and also we have the drug book coming from the wards daily, so that one can prove the other and he passes in that statement to the clerk and the clerk sends it to the prohibition officer.

THE CHAIR: I think that answers the question. "Would the interests of the public be best served by a member of the medical staff being a member of the board also?" Now this is a rather important question, because I know of one hospital that had a doctor on the board of directors, and there was always more or less friction until he was replaced by a layman. Every once in a while I get a letter from some superintendent asking whether we have a doctor on our board or not and whether it is a good thing to have a doctor on the board. I wish this question could be discussed a little for the benefit of this superintendent.

MR. FOWLER: I think that question has been pretty thoroughly discussed in informal meetings and it has been universally condemned, that is, to have in the Board of Trustees a medical man who is in active practice. If he is not in actual practice, the mischief is not so great.



DR. MACEACHERN: It has been my experience to know several boards where there is no friction between the board and the hospital; and speaking from experience I find that a well selected medical representative is of wonderful assistance to the hospital, and I have been using that system now for seven or eight years. I have had a different man every three years, and I want to tell you that I find them of tremendous help. In addition, our institution has the privilege of electing eight life governors, and always one of these governors is by accident a medical man and a representative of the city, and, in addition, a medical health officer of the city sits on the board. I have seen as many as four. We have never had any trouble and I attribute a great deal of development along the medical side to the assistance I got from the medical men. We must have a good connection between the medical men and the board. The Medical Staff Association have a direct communication through the representative who, of course, always confers with myself.

DR. MORSE: Dr. MacEachern evidently has a medical man who is very broadminded. Unfortunately, those who have had experience with having a medical man on the board of trustees have had the other side of it. The best organization is to have a committee representing the medical board and another committee representing the lay board of directors, termed the Joint Conference Committee. This committee should meet once a month and take up all questions of a medical administrative nature, so that the board will be in touch with the medical man and the medical man with the board. It is only the unusual physician who is big enough and unselfish enough to represent his staff with the board of trustees for the best interests of the hospital, and I believe the Joint Conference Committee is the only solution to the problem.

MR. GUSSIPPI: I want only to state the experience of the trustees of the Wilkesbarre Hospital—my city. We, for many years, have had on the board of seven, two physicians both of whom are members of the visiting staff of the hospital. I am one of them and have been reelected every three years for the last thirty years. There has never been any expression of dissatisfaction, as far as I know, with the medical members of the board. As has been stated by another speaker, it is an advantage to have one or two members of the visiting staff on the board, because it keeps the visiting staff in closer touch

with the board. I merely want to state the experience of my board.

A MEMBER: I speak as a trustee. We have on our board of trustees three physicians or surgeons, and two of them are members of the staff, and the experiment has proved very satisfactory indeed. Those physicians act as a sort of buffer between the staff and the board. If the staff gets fractious or rambunctious, the doctors can carry to them the sentiment of the board and tell them how far they can go and it has proved extremely satisfactory. And we have also that board of conciliation and harmony that the gentleman spoke of, but I can see from my standpoint as a trustee, no possible objection to having a medical man on the board of trustees.

A MEMBER: We have a provision in our province by which each hospital has an advisory committee of three on the board of directors, appointed by the medical staff. They have no voting power; and that plan works out very satisfactorily.

A MEMBER: At the Brooklyn Hospital, which I represent, one of the rules of the hospital permits any medical man to be a member of the board of trustees, but the attendants on four subjects meet each week with the superintendent. Once a month this committee of five, which is called the Attendants' Committee, meet with representatives of the executive committee of the board of trustees. In that way the professional staff of the hospital has direct contact with the superintendent of the hospital and with the board of trustees. It has worked out during the last three years very satisfactorily.

MR. BORDEN: I would like to ask a question: If you wanted a man to represent the doctors on the staff, would you pick out the surgeon or the orthopedist? We have three members of the advisory board of the staff who are entitled and invited to attend trustee meetings, but they have no vote. We also have consultations with the advisory board of the staff from time to time, and we find frequently that those three doctors do not agree. Which one of the three would you pick out to put on the board of trustees to represent the staff? If you are going to have a physician on the board of trustees, how would you have him appointed? Would he be elected by the staff, or would it be a provision of the bylaws that the trustees should consist of so many, one of whom must be a member of staff. Personally I think there are a great many problems that immediately arise when you

choose one member of the visiting staff to act on questions that come up, sometimes involving the views of the staff towards the hospital. Now, so far as having a member of the staff on the board of trustees to act as a buffer between the board of trustees and the staff, I must confess that I have no sentiments in that direction whatever. The trustees, when it comes to a point, if any doctor of the staff is not doing his duty properly, need no buffer; they should do their duty, and the difficulty which the member of the staff has with the board of trustees when that question comes up is that he may or may not be quite closely associated in some other way with the man who is subject to criticism, and either he does not vote or is put into a very difficult position and becomes subject to a lot of criticism. Now these suggestions, I may say, are not theoretical ones, they are more or less the product of hard experience and have been largely developed from experience in a hospital where medical men were members of the staff and my experience in a hospital where no physician was a member of the staff has been that the situation has been improved by a separation of those two very distinct departments of the hospital.

DR. DREW: I agree with Mr. Borden. Where I serve as head physician on the board of trustees, it is either an unwritten law, or I think perhaps it is part of the by-laws, that no member of the staff shall serve on the board of trustees. I think there is good reason for that, as Mr. Borden has indicated. If a member of the staff is on the board of trustees, there is no one likely to find any fault with him, for obvious reasons, but there is a good deal of jealousy among members of the staff, and if he is a man who wants to work things to his own advantage, he has every opportunity to do so, and I do not think it is a good plan, but a broadminded physician on the board of trustees is a decided asset, but he should not be on the staff. That, I think, will lead to trouble. Now we have an advisory board. One of the trustees has as his special duty, to visit the hospital frequently during the month and make representations, and prior to the monthly visits of the board, the advisory committee of the staff, consisting of three members, meet with the medical and surgical directory and superintendent to talk over any matters that may come up for the action of the board, and this visiting member for the month is always present, and in that way anyone who has an idea

that he wants to put through, has a chance to talk it over and get the benefit of the criticism before it is brought up to the board for action.

MR. PILGRIM: In the state of New York it is illegal for any member of the board of trustees to realize any financial profit from their connection with any institution, and in the event of a doctor becoming a member of the board of trustees, he would forfeit the privilege of sending a private patient on accepting a fee from any patient during his term of trusteeship. I think there are very few doctors who would be willing to do that.

A MEMBER: At the Woman's Hospital in New York, the attending surgeons are permitted to attend the meetings of the board of governors and take part in the discussion, but they have no vote.

THE CHAIR: The next question is, "What is the advantage of a monthly or quarterly bulletin? Should it be made up of hospital events, or strictly medical?" What is your experience? Is there any hospital printing a quarterly or monthly bulletin? I might say that the Presbyterian Hospital of Chicago, prints a quarterly bulletin. It consists principally of hospital events. We have a circulation of about a thousand. We find that it does a great deal of good, and I believe it is very profitable. It varies from twenty-five to forty pages. If anyone wishes a copy of that bulletin and will write me, I will be glad to mail one.

MR. FOWLER: I would like to inquire what are the practical results of sending that out?

THE CHAIR: It stimulates interest among the members of the women's board, the Nurses' Alumnae Association and other interests; they take a certain number of copies and pay for them, as also do friends of the hospital. They have the privilege of subscribing for it at fifty cents a year. "What is suggested as a means for creating a good impression in the minds of patients on admission?" Now that is rather interesting. I wish somebody would talk on it. I think many times we in the hospital do not realize that the patient coming to us into a strange place, and quite often has a very lonely feeling, and it is a wonderful thing for the clerk or somebody to give him just a little bit of personal interest, just a few words, sometimes, to make him feel that he is among friends and not in a cold institution. Can anyone tell us how they are overcoming that?

DR. MACEACHERN: I visited a hospital today, and, as

I entered the door, I noticed that the first one who met me was a good looking man, an orderly I suppose, well dressed, very polite, and I noticed that he not only handled visitors that way, but patients coming in. I have found that the first one who greets the patient is the one who makes the impression. I have found that there is a certain time we have to wait, and a few minutes waiting seems like half an hour, and there is where you get your complaints. So we arrange a large and attractive waiting room, with a large number of pictures and a large number of bulletins, and I frequently find patients come in who have forgotten something or they want to telephone their friends that they have arrived safely, and we have a little telephone table and on it we keep a picture that we change from time to time, so if they have to wait a little while they have something to look at. On one or two occasions we have had trouble putting our patients into the ward when they were ready to be admitted, because they wanted to see the pictures and wanted to read the bulletins. Not only has it a psychic effect, but it has an educational effect on the patient. They become impressed with the institution and it develops confidence. They see some of its workings, which is properly censored before their visit, because to show them an operating room and an operation going on would be very unwise.

MR. LODER: At Waterbury Hospital, Waterbury, Conn., an institution of 180 beds capacity, with an admission of 15 new patients a day, they have determined to employ an admittance clerk, who goes on duty for the first time next Monday. That was brought about because of the criticism of the public on the time taken for admitting patients, and also on account of the neglect accorded to new patients. This was also organized through the appointing of a special committee on admission by the members of the medical board, and also of another committee on the inside of the hospital, consisting of representatives of the office and of the telephone department and of the house doctors. Those two committees, consolidated into one, met and worked out the plan, whereby there is to be one admission for all patients, there is to be a room fitted up at the entrance, that the clerk in charge is to make that duty her first one and her only obligation, doing other work in the hospital when she is not on that task, but of a nature that will not take her away from that task. Now they are going

to have in that room at the entrance a little emergency equipment in the way of a wheeled chair, etc., and that clerk will take a patient, if it is an emergency case, to the emergency room. If the patient is to go to the private room or to the ward, that patient will be taken to his bed in that department. There will also be taken by that clerk, the admission and the history usually customary, including the collection of the first week's charge, and other duties of the kind will rest with that clerk, working in association with the other departments of the hospital. It is believed that this will remedy a great fault and a great criticism that has been resting against that hospital for some time.

A MEMBER: I want to speak for the Research Hospital, in Kansas City; I was there about six years, and that same plan was used there during all that time. I am not there now, but wanted to mention it for them.

THE CHAIR: We will take up the next question. I have about fifty more questions, so we must hurry along. "What has been the experience of superintendents in hospitals where active campaigns are being waged to better their case records? What has been the experience of superintendents in organizing and instituting monthly meetings of their medical staff to review case records?" I suppose somebody has been trying to carry out the minimum standards as set down by the American College of Surgeons, and has had a little trouble doing so? Can anyone throw any light on this subject?

DR. SUMNER: It might be interesting to the members at this Convention to know that the Commissioner of Public Welfare of the City of New York has just issued an order that the Record Room in the Departmental Hospital shall be in charge of a trained nurse. That will be one step along the line of getting better records.

DR. MOSS: I should like to say that all those delegates returning to their homes through the city of New York should make it their business to visit the Woman's Hospital in that city and see the wonderful organization effected by Dr. Ward, the surgeon in charge. He has meetings of the staff every Thursday afternoon from five to six o'clock, and during that one hour every history, practically, of that institution is reviewed in the presence of the entire staff. It is really worth while visiting that institution, and I certainly would urge each and every one of you to see with your own eyes what can be accomplished in so short a time. I think they have a rep-



representative here who might say a few more words in that regard—a representative from the Woman's Hospital.

A MEMBER: I think that Dr. Moss has given a short summary of what Dr. Ward has done. Every infection, every casualty, has to be reported by the head of each service, and that includes Dr. Ward's services as well.

THE CHAIR: The next question is, "Do hospital superintendents attend the medical staff meetings?" Are any of you here invited to attend the medical staff meetings? Quite a large number. How many do not attend? It is about even. Has anyone anything to say on this subject?

MR. FOWLER: I think it is a very good thing to have the superintendents meet with the medical men. I have been talking about getting my men together, and conferring occasionally, and I hope to succeed.

THE CHAIR: For the benefit of the member who asked this question, I will say that the superintendent of the Presbyterian Hospital is invited to attend all the medical staff meetings; he gets a written notice the same as a member of the staff. "Authority of the superintendent over the staff." How many superintendents have authority over the staff? "To whom are internes directly responsible?" Now this question is asked by a trustee. I imagine there is some trouble there. I find in talking with superintendents that in some hospitals the medical staffs think they run the internes and that the superintendent has nothing to say about it, and that in other hospitals, the superintendent runs the internes and the medical staff do not have anything to say about it. Really it is a subject that is worrying some of the superintendents. I would like a short discussion on it.

DR. MOSS: I believe that is a very simple question to answer. If it is a question of the actual medical care of the patient, it seems to me that the staff are directly in charge. If it is an administrative question I believe the superintendent should be the superior officer; that is the way it is in my hospital.

THE CHAIR: It is the same in the Presbyterian Hospital. I think that is the proper solution of it. We have had that rule in effect for twenty years or more, and it works very well. The interne is responsible to the medical staff or to his chief for his medical work. In the matter of discipline or anything pertaining to the welfare of the patient other than medical, he is under the superintendent.

A MEMBER: Might I ask if the medical staff is not directly responsible to the board of directors?

THE CHAIR: Yes, sir.

A MEMBER: Then the superintendent, as the representative of the board of directors, has some authority over the staff, has he not?

THE CHAIR: Yes, he should have.. "How far should the average hospital attempt to pursue research work?" Has anyone anything to say on this subject?

MR. PILGRIM: A hospital should not attempt research work until it becomes above the average.

THE CHAIR: Has any hospital that is doing research work anything to say—any superintendent whose hospital is doing research work?

DR. WILSON: To the extreme extent of its ability.

THE CHAIR: "Should the hospital encourage autopsy work? How do you obtain permission from relatives and friends?"

MISS SAFFEIR: It is up to the superintendent to try to the utmost to get permission.

MR. FOWLER: I think we can get an expression by asking those who favor the first part of that question to raise their hands.

(The Chairman did as suggested and the response was affirmed practically unanimous.)

A MEMBER: The question might well be put, "Can anything logically be done to eliminate the difficulty in getting autopsies which are not coming directly from the patients?" In one city I know of we fail to obtain autopsies, not on account of the prejudice of the patient, but because the undertakers discourage the practice, going so far as to make an extra charge and telling the relations all kinds of things to discourage them from giving us an autopsy. We lose many of our autopsies after we practically obtain permission, because as soon as the fact becomes known, the undertaker prejudices the family. The undertakers are in an association, most of them, but even legitimate undertakers in their association, apparently do not recognize or take into consideration the harm they are doing by discouraging autopsies.

THE CHAIR: You do get permission?

A MEMBER: Yes, sir.

THE CHAIR: Then the undertaker has nothing to say about it.

A MEMBER: No,—not after the permission is signed, but we happen to be a municipal institution and it is better

to lose the autopsy than to hurt ourselves and maybe take another year to get over some scandal that he will bring up, but it is a fact that the undertakers do work against us and cause us to lose many of our autopsies that we would otherwise get. It is very discouraging, but we do not feel like antagonizing the undertaker, and you cannot afford to do it, because you hurt your chances of obtaining autopsies if you do.

DR. MOSS: Is the prejudice existing in the minds of the undertakers against the performance of the autopsies?

A MEMBER: It is the extra work that it causes them.

DR. MORSE: It seems to me that it would be apropos to call a little conference with the five or six or a dozen undertakers in your community, tell them your difficulties and ask their cooperation. I am sure you will find them a very cooperative crowd of men.

A MEMBER: Absolutely not; it is a cold matter of dollars and cents with them, and many of our patients are poor people, so five or ten dollars stuck on their bill simply means that we do not get the autopsy.

A MEMBER: I am quite sure it is the same in New Jersey and more or less in the state of New York. If I have been told correctly by hospital superintendents in New York City, they have the same trouble. When I talk with our undertakers, they say yes, they will try, but let the clerk at the desk try to handle it, and they will influence the people to a greater or less extent against the autopsy.

MR. FOWLER: It has been my experience also, that there is an opposition on the part of undertakers which is somewhat effectual in deterring people from allowing autopsies.

THE CHAIR: "Are distilled liquors at all necessary in the operation of a hospital?" I imagine this superintendent does not mean the alcohol used for bathing, etc.; I think it means brandy, wines, etc., for medicinal purposes. I might say for the benefit of this superintendent, that when the prohibition law went into effect a year ago, the first of July, the Presbyterian Hospital discontinued the use of alcoholic liquors. We had a very small stock and locked it up and it is still locked up. We do not use it. Before taking up the next question, a slip has been handed me asking that this Convention go on record as recommending to the trustees of different hospitals to have their superintendents present at their monthly meetings.

Will someone put that as a motion and let us put it through and settle it.

MISS SAFFEIR: I make that as a motion.

(The motion was seconded and unanimously adopted.)

MR. FOWLER: I wish to ask how this resolution is to get to the notice of the trustees?

THE CHAIR: It will be printed; it might be in the bulletin.

MR. FOWLER: I think it would be well to have it come officially from the American Hospital Association in a circular letter.

THE CHAIR: I have another question just handed me; "Should self-government be introduced in training schools for nurses?" We cannot get away from the nursing question.

(Cries of "Yes.")

THE CHAIR: I think the superintendent who asked this would like to have you tell him why.

A MEMBER: I tried to have it in my training school and my nurses did not want it.

MISS SAFFEIR: We have it in our training school for the last three years; it works very well. Of course it is under the supervision of the assistant superintendent, who is the honorary chairman always, and I would always recommend self-government for our nurses, provided it is supervised by the training school.

A MEMBER: That is cooperative government, not self-government.

MR. PILGRIM: In all educational institutions, control is necessary and essential, and self-government is practically impossible.

DR. MOSS: This is a very important question, and in view of the fact that I have recently gone through an experience, I believe that this discussion will be very elucidating. A certain institution has, within the past six months, established self-government for nurses, and the first case that occurred and was presented to the student body was the matter of a nurse guilty of certain charges, and the superintendent of the nurses practically decided to expel that nurse. She called a meeting of the student body for a particular evening, but the afternoon before the meeting, the superintendent of nurses went to one of the student body and said, "I want you to make a motion that this nurse be expelled." She went then to a second nurse and asked her to second the motion, and that nurse was expelled that very same evening. The superinten-

dent of nurses said, "If you do not expel her, I am going to expel her anyway," so that is the situation; although this particular institution had a self-governing body, the body was practically influenced and governed by the superintendent of nurses.

MISS SAFFEIR: That is not right.

THE CHAIR: Is there any further discussion? If not we will pass on to the next question; "Should it be made compulsory that all physicians and surgeons practicing in hospitals, sign a pledge against fee division? What are the many forms of fee-splitting? Are all forms bad?" Does anyone care to discuss this subject?

MR. PILGRIM: I would not like to ask my doctor to sign a pledge against fee-splitting; I would fear I was insulting him.

DR. MACEACHERN: There is a good deal of controversy about this question most hospitals having their physicians sign a card which eliminates fee-splitting. I found that in the hospital standardization program last year there was a great controversy over fee-splitting among medical men and we could only summarize by saying that it was not fee-splitting and they knew what they were paid; that is, every doctor would send in his statement of services rendered and amount of his charge for the same. Any method that does not show the patient distinctly what he is paying for is fee-splitting. That might mean that a man sending a case to a surgeon would put in his bill for the free treatment and diagnosis, and the surgeon would put in his bill for his work. The bills might be pretty near alike in amount, because we believe that the internes making the diagnosis should be paid more; however, if the bills are itemized, that patient knows that it is not fee-splitting, although some people would think that was. I think the only solution we can arrive at is that the patients must know what they are paying and what for and to whom.

THE CHAIR: Is there any further discussion of this subject? "What, if any difficulty do you have in securing diagnosis and history from patients?" I think they must mean securing the history from the patient, not the diagnosis. I would answer that question by saying that if any patient refuses to give the necessary data for the history, you have a right to refuse his admission, unless an emergency case. "Should the dietitian purchase food supplies? If so, why?" If the superintendent who asked that question would turn to last year's proceedings, he

will find it answered. "Should hospitals operating at a considerable loss, buy staple supplies, such as sugar, flour, canned goods, gauze, linen, etc., for future delivery, or, say, a year's supply in advance, or live a hand-to-mouth existence?" Does anyone care to say anything on this subject? I should say that while the prices are so high, it would be better to buy pretty close and very close and very carefully, not to load up on anything. Personally, I buy from hand to mouth and intend to do so as long as prices stay up. "What is the feasibility of hospitals owning a farm?" (Laughter.) "Is there any financial saving?" I wish we had a farmer here in the house to answer that question; I cannot.

DR. WILSON: The Public Health Service has operated a farm in connection with its sanitarium for a number of years. I think the question can be answered categorically. "Yes sir, it pays to run a farm." It does not always pay in any particular year to run a farm; sometimes the farm runs at a dead loss, but if you will take it through a series of years and have a scientific farmer, the answer is "Yes." Now in the hospital with which I am at present connected, we have 516 acres; 75 are under cultivation. This summer we have supplied garden truck very largely for our needs, and also shipped to hospitals in Baltimore and Washington. The farm has been a dead loss; we expected it to be that; we undertook it with the distinct understanding that we would not be blamed if it were a dead loss this year. Next year we do not expect to split even, but at the end of the third year, if we cannot show that we are at last beginning to come out whole and make it a paying proposition, I will stake my reputation on it and ask to be transferred at the end of that time.

DR. WALLENBERG: I have had occasion to run a farm; I am running the Alms house farm of 120 acres; we can use the alms house labor on that farm and it is paying. The other farm, of 360 acres, situated in one of the richest counties in California, has been a loss for 12 years because we have to hire the labor. Three years ago I turned that farm over on shares to some Portuguese in the district, and now we are making a few hundred dollars a year out of it on shares. We cannot run the farm and make money on it where we have to hire labor.

THE CHAIR: I think that answers the question pretty well. We have got back to the mattresses and pillows again. "How shall mattresses and pillows be purchased?"



Now that really is a very important question. I have taken particular pains to visit some of the places in Chicago where they make mattresses and pillows, and I want to tell you that a great many of them made in these places I would not care to sleep on, and I think we ought to be very careful how we purchase mattresses and pillows for our sick people to sleep on, especially as they have to be in bed 24 hours out of the 24. A great many of them are nothing more nor less than the most insanitary sweatshops. Furthermore, I have found out that in some of our cities, the rag peddlers buy up old mattresses, filthy old mattresses, and put new ticks on them and sell them for new, without sterilization or cleaning. This is a very important subject. We should know where our mattresses and pillows are coming from when we buy them, and only buy from reputable firms that we know are all right.

DR. WILSON: In the State of New York there is a regulation of the State Department of Health which provides that every mattress-making concern that renovates mattresses must sterilize these mattresses, either by the use of formaldehyde gas in a vacuum chamber or an autoclave or flowing steam, but they must be sterilized. When a mattress costs \$30, throwing it away means something. Mattresses should be made over. We in our own department usually send them to the manufacturer from whom we purchase them. However, there is a blind asylum I know of in Brooklyn which does equally good work, but mattresses should be saved and should be renovated; there is no doubt about that.

THE CHAIR: "Should patients be allowed to make a selection of food?"

MR. LODER: Many hospitals find it a matter of utility and also one of economy, and further, one of greater satisfaction to the patients, if they have a prepared menu in somewhat of a blank form, that is, for their breakfast, dinner and supper; they have a list of things from which a patient may select. For instance, for breakfast, there will be listed fruit and cereals, cooked and uncooked, and then eggs, butter, milk, cream, coffee, tea, etc., and there will also be included there the main order. Now whatever the food may be will be written on the key slip. These slips are taken at a certain time and presented to the patient by the attending nurse, and those things selected by the patient are checked. That slip is then passed back to the kitchen or to the diet kitchen and the

tray is filled and those items checked. The advantage of the plan is that the patients feel that they have something to say about their own diets. The advantage to the hospital is that you cut down the loss on foods that you would have served under the general diet plan, and I have been able to calculate in a hospital of 100 beds you will save probably \$1,200 or \$1,500 annually in your food bill under that plan, provided you work it out and adapt a system to your own institution.

THE CHAIR: Is there any further discussion? "Are you in favor of a cafeteria system for nurses? Do they like it?" I hear a great many "noes." Are there any "yeas?"

A MEMBER: In Salt Lake City we have had a cafeteria for nurses eighteen months and the nurses like it much better. There is less waste for the hospital and there is less confusion, and as we have difficulty in getting help out west, that means something to us. The food is there and the nurses can make their choice of the food. If they do not want certain dishes, they do not have to take them, and we find it much better.

THE CHAIR: How large a school have you?

A MEMBER: We should have 50 nurses and did have when we started, altho we have not that many now, but the special nurses, internes, housekeeper, dietitian and myself all have the same.

THE CHAIR: Is there anyone here who has tried out the cafeteria system and gone back to the old system? I would like to get a little further information for this superintendent if we can. Evidently she is thinking of starting the cafeteria system. I know that some have started it and given it up, and some have it and probably would like to give it up.

MISS KEITH: The hospital I know best has had a cafeteria for two years, and we have no idea of giving it up. We have had new cafeteria equipment installed. We took to it because we could not get help, but the service is very prompt and it is run through by the serving counter and we have had no requests to have the old system back. When we started it, we were to have cafeteria service twice a day, and service at one meal, but the pupils asked to have the service for the one meal discontinued, and even when we were prepared to give it, they would take their tray and come in, preferring cafeteria service. The nurses like it very much better than any other service we are able to provide for them under the circumstances.

MR. FOWLER: It would be interesting to know how many here have tried the cafeteria system and after that, how many have given it up.

THE CHAIR: How many have tried the cafeteria system? Several. How many have given it up? Several.

A MEMBER: I wish to testify for the cafeteria. I am from the Howard Hospital. We have had it since last January, and I would not go back to the old system. The meals are hot, the nurses well supplied, and it is one of the greatest things we have ever introduced.

A MEMBER: Before we leave that question, might we ask the reason of those who did give it up?

THE CHAIR: I asked the members if any gave it up, why, but they seemed a little reluctant to tell us. Is there anyone who has given it up, who will tell us why? No response. "Is there any advantage in having the dietitian subservient to the superintendent of nurses?" Now this question probably is troubling some superintendent. In some of our hospitals the dietitian is under the superintendent of nurses, and in some she is under the superintendent of the hospital. Can any of you give your experience that will help this superintendent?

MR. PILGRIM: As a sympathizer of nurses who have complete control of the training school for nurses, I think the dietitian should be directly under the control of the supervisor of nurses.

THE CHAIR: Has anyone else anything to say? If not, we will pass to the next subject?

DR. WILSON: Before we leave that subject—in the Public Health Service they have made the dietitian directly responsible to the superintendent, or to the officer who corresponds to the superintendent of hospitals. We believe that the dietitian should not be responsible to the superintendent of nurses, that she should consult with her, and they should work in cooperation, but that her immediate superior officer should be the commanding officer of the hospital, which corresponds to the superintendent of civilian hospitals.

THE CHAIR: "To what extent should there be supervision of the ordering of special foods for patients?" I imagine that the superintendent who asked this question wants to know to what extent should the dietitian supervise the ordering of special food for patients. I think we will have to pass that question up. There is one superintendent who evidently is very much worried about the writing up of histories, and I can see how the small hos-

pitals that have no internes and that is trying to comply with the minimum standards as set down by the American Hospital Association and the American College of Surgeons, have rather a difficult problem here to solve; and this question comes in; "Who takes the history when there is no interne?"

A MEMBER: Was not that question answered at the Round Table last year in Cincinnati? One superintendent advised that he was conducting a small institution and had experienced great difficulty in getting histories taken, but that practically all the patients cared for in his institution were sent to the institution by the visiting men, operating and caring for patients in the institution, and that the hospital being unable to get the histories any other way, had provided the members of the medical board with cards having a carbon insert, and when the visiting physician took the history of the patient before sending the patient to the hospital, he took the history on one of these cards and retained the original for his files and sent the duplicate to the hospital. That was answered last year.

A MEMBER: We have installed, since January 1, the medical records system laid out by the College of Surgeons. We have no internes, but we use the dictaphone in place of the interne. Ours is a small hospital.

THE CHAIR: That is a very good suggestion. I think that will help the superintendent in trying to solve the problem, by the use of the dictaphone.

DR. MOSS: I should like to ask this question; it is easy enough to get the dictaphone, but how about the stenographer who takes the dictation? Should not she be a trained worker who understands medical terms?

A MEMBER: Fortunately the stenographer we have has been with us six years and knows medical terms. She uses the medical dictionary and transcribes from a transcribing machine and types it off. She devotes most of her time to that in connection with bookkeeping.

DR. MOSS: May I ask what you pay her?

A MEMBER: \$75 a month and her maintenance.

MR. BORDEN: I want to make one suggestion, and that is, when you start in, make it a rule to insist that your stenographer is not to take any dictation except by the dictaphone, because as soon as the doctors find out there is a stenographer there who transcribes their histories they will try to go directly to the stenographer and dictate to her, but if you make the rule and insist that it be

obeyed, they will then begin to use the dictaphone. The objection to the personal dictation is that the doctor who gets the first call has the advantage and the time of the stenographer is then his and not the time of all the other members.

A MEMBER: In the use of the dictaphone I would like to ask one question; who checks up the transcript? Does the stenographer hand the history back to the doctor and then does the doctor check up against the dictaphone? How do you know that the history is actually transcribed as the doctor gave it?

A MEMBER: The history is placed on the patient's chart and the doctor reads it.

A MEMBER: And makes longhand corrections?

A MEMBER: Yes, if there are any. The typist is familiar with the voices through the transcribing machine. Some of the doctors do not talk very distinctly; therefore she has to call that man's attention to it and go over it. We have a regular system; the records are transcribed every day and the doctor O. K.'s that history. The doctor is not supposed to leave the operating rooms until the operation is dictated. We are a small hospital. We have one dictaphone in the operating room and one on the floor. The one in the operating room stays there and we have a room especially for the doctor to go into and talk into the dictaphone so that no one else hears it.

A MEMBER: I represent the Rochester Homeopathic Hospital. During the war we were absolutely without internes for a time and we furnished a stenographer who went with our staff physicians to the ward and took their histories for them as they took it from the patients, and transcribed it on the typewriter.

THE CHAIR: We have more questions, but it is getting late and as I want to throw the meeting open for a short time, so if anyone has a question that has not been brought up, he can ask it. Any questions that have not been answered will be answered by mail after being submitted to the advisory committee. The meeting is now open, if anyone would like to ask questions. If not, a motion to adjourn will be in order.

The Round Table then adjourned.

AMERICAN HOSPITAL ASSOCIATION  
AMERICAN CONFERENCE ON HOSPITAL SERVICE  
AMERICAN ASSOCIATION OF HOSPITAL  
SOCIAL WORKERS

TWENTY-SECOND ANNUAL CONFERENCE

Montreal, October 8, 1920, 10 A. M.

PRESIDENT HOWLAND in the Chair.

THE CHAIR: This is the second combined conference of the American Hospital Association, the American Conference on Hospital Service, which, as you know, is a combination of many organizations all interested in the broadest way in hospital service. The first matter before the conference is an address by Dr. Frank Billings, president of the American Conference on Hospital Service.

DR. BILLINGS: On the program I am assigned to the duty of reporting upon the service which the Conference can now render to hospital personnel through the Hospital Library and Service Bureau, and in addition to what I have to say about that, I desire to read to you something concerning the Conference, concerning certain principles and policies upon which we desire advice from those assembled. Since the last joint conference, the Conference has been incorporated in the state of Illinois, with headquarters in Chicago at 22 East Ontario Street, in a building owned by the Modern Hospital Publishing Company. A library committee has been appointed to formulate plans of work and formulate the functions of the library. In a brief prepared by Dr. Warner, the whole subject is covered in principle, and I desire to read that to you as a part of this report upon the library.

The proposed Library and Service Bureau will collect, classify for reference, use and distribute type of data as outlined below. Pamphlets and data will also be collected and filed in such form as to be readily available to make up bundles to be sent out in answer to inquiries:

1. Plans, drawings and other data pertaining to the construction of hospitals, dispensaries, first aid rooms, etc. Also follow-up of all new hospitals within one year of their opening for the purpose of appraising efficiency and adaptability of architectural arrangement.

2. Complete record of hospital architects, with lists of hospitals planned by them.



3. Records of equipment in new hospitals, dispensaries, etc., and a follow-up for the purpose of ascertaining what part of the equipment proved unnecessary and what additional equipment was found necessary.

4. Indexes of hospital supplies and equipment, and equipment necessary for certain work, with cost estimates.

5. Case record systems with discussions and comparative data.

6. Health and hospital literature and reference material on community problems, vital statistics, social service, public health nursing, legal subjects, new laws and pending legislation affecting hospitals.

7. Material and data concerning preliminary educational and publicity work incident to the promotion of hospitals. Data on preliminary and permanent organization of hospital boards and information regarding methods of business organization and financing.

8. Lists of names of suitable and desirable persons with the records of their work will be kept available for those desiring to employ persons for special work, as for various surveys, campaigns, etc., and for expert advice on various subjects.

9. Complete records of all organizations and associations in the hospital-health field, with names of officials, information as to purposes, scope and places of meeting.

10. Information as to internal organization and management and function and work of the various departments.

### *Clientele to Be Served*

The Library and Service Bureau will give such reference service to its clientele in person or by mail as may be requested within the scope of its material. This clientele will comprise the following:

1. Hospital, medical, nursing and health organizations and publications; and the trustees, organizers and proprietors of these.

2. Hospital organizers, trustees, superintendents, staff members, department heads and other executives in official capacity or as individuals.

3. Building committees and committees organized for the promotion of a hospital project.

4. Directors of dispensaries and first aid workers in industries, schools and colleges.

5. Architects.

6. Public officials.

Others having practical needs.

In the minutes of the last Board of Trustees, some of you had the advantage probably of copies of these minutes, and on the question of forming a budget and obtaining the financial means to carry on the library, I will read the following letter written to Dr. Warner on May 27, 1920:

THE ROCKEFELLER FOUNDATION

61 Broadway, New York

May 27, 1920.

My dear Dr. Warner:

I have the honor to inform you that at a meeting of the Rockefeller Foundation held Wednesday, May 26, 1920, the following resolutions were adopted:

RESOLVED, That the sum of Fifteen thousand dollars (\$15,000) be, and it is hereby, appropriated to the AMERICAN CONFERENCE ON HOSPITAL SERVICE for the equipment and maintenance of a LIBRARY AND SERVICE BUREAU, on condition that not less than Five thousand dollars (\$5,000) is contributed for the same purpose from other sources, and

RESOLVED. That the Foundation pledge itself to appropriate the sum of Ten thousand dollars (\$10,000) in 1921 and the sum of Five thousand dollars (\$5,000) in 1922, on condition that sums of \$5,000 and \$10,000 respectively are raised from other sources in these years.

I understand from your statement that a contribution of \$5,000 from sources other than the Rockefeller Foundation is already pledged or underwritten. If this is the case, the Foundation will stand ready to make payments on account of its appropriation pro rata as other payments are received, that is as \$1,000 is received from other sources the Foundation will be glad to meet this by the payment of \$3,000. If you will confirm my understanding that the other sum is pledged or underwritten and later let me know as sums come in from other sources, I shall see that pro rata payments are made promptly by the Foundation.

I am very glad that it is possible for the Foundation to assist in what I believe will be an important service to hospital development.

Very truly yours,

Dr. A. R. Warner,  
American Conference on Hospital Service,  
22 East Ontario St.,  
Chicago, Ill.  
ERE:S

(Signed) EDWIN R. EMBREE,  
Secretary.

It has been estimated by the Trustees that a necessary budget for the year ending June 30, 1921, and June 30, 1922, would be \$20,000, and probably for the third year, ending June 30, 1923, would be \$15,000. That probably will meet the needs of the library in those 3 years. Already the \$5,000 necessary to complete the budget for this year, ending June 30, 1921, has been secured, and in all probability there will be no difficulty in securing the remainder from the constituent organizations of the Conference, from corporations outside who are interested in the library and from individuals. You will hear more concerning the finances from the Treasurer, who will have a report.

(Dr. Billings then concluded the reading of his paper.)

Since the first meeting of this Conference on September 9-12, 1919, at Cincinnati, the incorporation of the American Conference on Hospital Service has been perfected in Illinois and headquarters have been established in Chicago. Many of you who are here today are to be congratulated upon the fact that it was through your influence and active cooperation that this Conference has become an established fact.

It has been an illuminating privilege to read the papers and discussions presented by the representatives of the national organization which constitute the Conference and of other individuals who are interested in the improvement of hospital service, which took place at the conference on hospital standardization held in Chicago on April 21, 1919, and at the first meeting of this Conference at Cincinnati last September.

Those who were present at these conferences or who read the proceedings of the meetings must be impressed with the unanimity of the expressed sentiment in regard to the need of cooperative and coordinated effort of all agencies engaged in the work of improvement of hospital and of service to patients. The United States and Canada are fortunate in having so many citizens of high ideals, splendid vision, and above all a common desire to improve the medical care of the sick and injured, disregarding of the too frequent causes of non-cooperation through differences engendered by sex, race, religion, politics, rivalry in professional organizations, and the like.

Supported by the constituent organizations, by other corporations and by individuals, the Conference as a going agency is in a position to function and to grow and develop into greater usefulness with each succeeding year.

## *Hospital Library and Service Bureau Organized*

The Hospital Library and Service Bureau has been organized by a very live committee. A director has been secured who, with the needed clerical assistants, is already engaged in collecting, compiling, and indexing data along the lines enumerated in an admirable brief formulated by your vice-president, Dr. A. R. Warner. I quote from his article, "The Purpose and Scope of the Library":

The proposed library and service bureau will collect, classify for reference use, and distribute types of data as outlined below. Pamphlets and data will also be collected and filed in such form as to be readily available to make up bundles and to be sent out in answer to inquiries.

(1) Plans, drawings, and other data pertaining to the construction of hospitals, dispensaries, first aid rooms, etc. Also follow-up of all new hospitals within one year of their opening for the purpose of appraising efficiency and adaptability of architectural arrangement.

(2) Complete record of hospital architects with lists of hospitals planned by them.

(3) Records of equipment in new hospitals, dispensaries, etc., and a follow-up for the purpose of ascertaining what part of the equipment proved unnecessary and what additional equipment was found necessary.

(4) Indexes of hospital supplies and equipment, and equipment necessary for certain work with cost estimates.

(5) Case record systems with discussions and comparative data.

(6) Health and hospital literature and reference material on community problems, vital statistics, social service, public health nursing, legal subjects, new laws and pending legislation affecting hospitals.

(7) Material and data concerning preliminary educational and publicity work incident to the promotion of hospitals. Data on preliminary work incident to the promotion of hospitals. Data on preliminary and permanent organization of hospital boards and information regarding methods of business organizations and financing.

(8) List of names of suitable and desirable persons with the records of their work will be kept available for those desiring to employ persons for special work, as for various surveys, campaigns, etc., and for expert advice on various subjects.

(9) Complete records of all organizations and associations in the hospital-health field, with names of officials,

information as to purposes, scope, and places of meeting.

(10) Information as to internal organization and management and function and work of the various departments.

Clientele to be served:

(1) Hospital, medical, nursing and health organizations and publications; and the trustees, organizers and proprietors of these.

(2) Hospital organizers, trustees, superintendents, medical staff members, department heads and other executives in official capacity or as individuals.

(3) Building committees and committees organized for the promotion of a hospital project.

(4) Directors of dispensaries and first aid workers in industries, schools and colleges.

(5) Architects.

(6) Public officials.

(7) Others having practical needs.

### *Principles and Policies of the Conference*

The chief object I have in view today is to present to you some of the apparent principles and policies which must govern the Conference in its relation to the constituent membership organizations and to the public. These I offer as suggestions for discussion, with the hope that definite principles and policies will be adopted for the guidance of the members and administrative officers until such time as changed conditions may require their modification.

I think we are all in agreement with the statement expressed by some speakers in former conferences that the *welfare of the patient and his adequate treatment is the chief obligation of the hospital*. Disease and injury prevention are very important; but in spite of the most efficient application of the best plans of modern sanitary science to disease and injury prevention, we shall have with us always the ill and injured people who require hospital care. Therefore, for the present, the main principle of this Conference should be that expressed in the attempt to improve and secure adequate hospital service for the sick and injured.

### *The Hospital, the Community Health Center*

The second principle is necessarily closely related, as it implies the obligation of the hospital as the health center of the community it serves.

Its organization should contemplate an out-patient department for ambulatory treatment, social medical care of convalescents and of others, prenatal and maternity instruction, infant and child welfare and the like. It should become a school of instruction on all of the subjects in which it functions, to its own personnel and on health matters to the public it serves. Not all hospitals may be at once developed upon the lines of the second principle, but as the first principle is applied, the second should be contemplated as a necessary factor of the hospital organization if it is to fulfill its full obligation to the public.

In the attempt to apply these principles, what policies and methods of procedure shall the Conference adopt?

In the discussion at former conferences much was said of the standardization of hospitals,—mainly with the idea of the accomplishment of what I have attempted to formulate as the first principle. The American College of Surgeons has established a minimum standard. This standard deals chiefly with the character of the medical staff; the organization of the staff; making, classifying, and filing complete clinical records of each patient; regular staff meetings not less frequent than once a month, in which the clinical records shall be the basis of discussion, analysis, and review, and requiring the hospital to maintain laboratory facilities, chemical, bacteriological, serological, radiographic, and fluoroscopic, with a personnel of qualified technicians. This standard has been accepted by many hospitals. The American Medical Association, through the Council on Medical Education, after years of investigation has collected, classified, filed, and published data in the *Journal*, with lists of hospitals rated upon certain required factors, as offering sufficiently good opportunity for intern service and, therefore, classified as approved by the Council. Other constituent organizations have secured data of importance relating to hospitals and hospital service in regard to nurses' training schools, medical social service, out-patient departments, diseases and injuries due to industrial pursuits, the hospital in relation to the employer, the employee, and the Workmen's Compensation Act, and much other information relating to adequate treatment of the hospital patient.

The minimum standard fixed by the American College of Surgeons, the required conditions for the rating of hospitals by the American Medical Association to become listed as approved for intern service, the standard fixed



for the curriculum and years of hospital training by certain training schools for nurses. are in the main satisfying from the point of view of those interested in institutions which are able to meet the requirements without embarrassment to finances and personnel.

### *Standards Must be Within Reach of All*

It is evident to us all, I think, that it will be impossible to fix a minimum standard for hospitals which meet the requirements of the first principle named (the adequate treatment of the patient) which will be accepted at once by the majority of the small hospitals (those with less than 100 beds) of the country. Therefore, I believe it should be a policy of the Conference to formulate the essential minimum requirements of hospital organizations, to correspond with the first principle, through a committee composed of one or more representatives of the constituent organizations. In a consideration of these minimum requirements the committee will doubtless accept, with or without modification, the minimum standard fixed by the American College of Surgeons, the American Medical Association, and other constituent organizations. We shall all agree, too, I believe, that while these minimum requirements must conform with the conditions which will insure adequate treatment of the patient, they must be practical and of a character which will permit their acceptance by all hospitals within a reasonable period of time. For those hospitals which function in the training of medical students, interns, and nurses the minimum requirements must necessarily include factors which are not essential to the large number of hospitals which are not connected with medical schools and do not embody the training of nurses.

If the Conference adopt these suggested methods of formulating the factors of minimum requirements for the standardization of hospitals, I ask consideration of principles and policies to govern the methods of procedure which must be taken up coincidentally with or immediately following the conclusion of the Committee on Standardization.

The principle involved is fundamental if we are to obtain the object sought. It involves practical cooperation and coordination of effort of all the constituent organizations of the Conference in their adopted respective fields of work for hospital betterment. I would suggest that the policy to be pursued under this principle shall be

the agreement upon the part of each constituent organization to continue in its elected field of investigation of, and the improvement of, the involved factors of hospital betterment. For example, the American College of Surgeons is chiefly interested in the elevation of the standards of surgical practice; the Council on Medical Education and Hospitals is chiefly engaged in the attempt to improve the standards of hospitals which function in medical teaching, including the fifth or intern year; the State Medical Licensing Board and the Association of American Medical Colleges are also chiefly interested in the same subject; the American Nurses' Association is chiefly interested in the maintenance of high standards of its training schools and in the legal licensure of nurses; the Catholic Hospital Association of the United States and Canada is chiefly interested in the improvement of hospitals and of service in those institutions conducted by the Brotherhoods and by the Sisterhoods of the Church; the American Hospital Association has a wider field of endeavor, including standardization of hospital administration, plans for hospital buildings, materials of construction, types of hospitals and organizations suitable for different communities, and the like; and other constituent organizations have their own particular problems to meet. All are fundamentally interested in the improvement of hospitals to the end that adequate treatment may be given the patients.

### *Policy of Co-operation Urged*

It will be an economy of time and money if this policy of cooperation include avoidance of duplication of the work of investigation, whether this be by personal visitation, by questionnaires sent through the mail, or by other methods.

I would also suggest the further cooperation of the members of the Conference by the adoption of a policy which will make the Hospital Library and Service Bureau the repository and clearing house of all data concerning hospitals which may be obtained by each constituent organization in its respective field of work. Each organization may keep, if it so elect, files of its own acquired data, copies of which should be sent to the library at headquarters of the Conference in Chicago. This data would then be properly classified and filed. It is understood, of course, that the personnel at the headquarters of the Conference will be engaged in securing, classifying, and filing

data concerning hospitals which must be secured through its own initiative. The data which the personnel at headquarters may collect from various sources outside of the organizations which constitute the Conference are enumerated above in the quotation from the brief prepared by Dr. A. R. Warner. The accumulated data are owned by the Conference,—that is, in reality owned by the constituent membership, and are readily available for the use of all.

To the end that the policy of cooperation in the field of investigation of hospitals may be carried on economically and efficiently, I would suggest the appointment of a committee composed of representatives of the constituent organizations of the Conference to formulate methods of investigation, to standardize the methods, to assign, with the consent of each, the field of investigation of each constituent organization and so to plan the investigation of the whole hospital field that duplication of work will be avoided as far as may be possible.

In this short address I have endeavored to bring to your attention what I believe to be the most important subjects which need to be settled by the Conference at this time. As stated, I have offered the expressed principles and policies as suggestions for discussion. I also hope that we will approach these subjects in a spirit of mutual sympathetic understanding of the embarrassment which many of the constituent organizations face in the attempt to solve the problems in their own organizations and fields of work. The object of all of the members of the Conference is a desire to improve hospitals in the sense of more adequate treatment of the sick and injured. This object will be a difficult one to solve for a majority of the hospitals of the United States and Canada; but it can be done if we work with understanding in a cooperative way. It will require years of endeavor, but each year will see the accomplishment of much work which will make the work each succeeding year less difficult, and success will at last crown our efforts.

Dr. Frank Billings takes the chair.

THE CHAIR: Dr. Howland has conferred on me the honor of presiding for the remainder of this session. I accept that responsibility with a good deal of embarrassment. May I ask you if you will proceed with the remainder of the program and have discussions, or do you wish to discuss the paper presented, or do you wish other papers presented at this time? If there is no objection, I will ask for the reports of various committees and then

open the field for discussion, but I do hope that the paper I have presented may offer subjects for discussion for the guidance of trustees and the delegates of the Conference. The next on the program is a summary of reports, first by Dr. John M. Dodson, dean of Rush Medical College, Chicago.

DR. JOHN M. DODSON: As President Billings has so clearly indicated, the purpose of the organization of that Conference a year ago was to secure a degree of cooperation and coordination among the numerous interests and organizations concerned in hospital work. One of the ways in which we dissipate an enormous amount of time and energy and money in this country is by many organizations seeking a common end, working without knowledge of what each other is doing or without any effort to work effectively together. It is to be hoped that we can secure a better degree of cooperation among the associations through this Conference. For obvious reasons it seemed wise to make the Conference a delegate affair, two delegates from each of the fourteen organizations, which seemed, at the time, the most proper ones to be associated in that effort. These twenty-eight individuals can accomplish very little indeed as individuals; they can be effective only in this movement if they have, back of them, solidly and forcefully and continuously the interest and support of the organizations which they represent, and among those organizations none is more important than the American Hospital Association, which, in any way, is concerned in larger range of hospital activities than any other. If these organizations are to co-operate effectively, it is essential that each should know what the others are doing, and so the Trustees, I think very wisely, at their meeting in March, decided at this meeting there should be presented, first, a summary of the present activities and purposes of the several medical organizations. And so I am here to present you what has been done by the five associations of physicians which are represented in this Conference. The largest of these Medical organizations is, of course, the American Medical Association. The American Medical Association is, of course, the great Association, the Federated organization, of the medical profession of America, and represents in its constituent county and state medical societies, something over 80,000 physicians, probably four-fifths of those in active practice in the United States. Of course its members are interested in all phases of hospital

activity. It has, on numerous occasions, in state and national meetings, discussed problems even from construction down, but officially its activities have been concerned almost wholly with the problem of internships and interne education. As long ago as 1903, when its council on medical education was organized for the purpose of studying the problem of medical education, a problem which it has solved with wonderful efficiency, it began to gather information about hospitals, through state committees of physicians who apparently were familiar or could become familiar with the institutions in their states. In 1912 a list of hospitals was published in this connection. As early as 1905, recommending as it did that an interne or hospital year be required for graduation from a medical school or at least as a preliminary to practice, it became interested in this phase of the question, so that in the course of those years, it has gathered an enormous amount of information, much more than even the members of the medical profession had any idea of. The name of the council has been changed this spring to that of Medical Education and Hospitals, and now the information is becoming very well organized, and on the basis of it, four lists of hospitals, so-called approved hospitals, for interne education have been published. These have not been graded, as in the case of medical schools, that is for publication, but quietly the Council has listed these hospitals in that way for the guidance of medical schools and state boards, so that it has provided a group of thoroughly approved hospitals, group A; group B, approved for hospital interne education with certain improvements; group C, not satisfactory at all, and another group below C.

The Association of American Medical Colleges is an association of some 65 or 70 of the medical colleges of the United States. They meet annually, as a rule at the time of meeting of the Council on Medical Education, and have certain minimum standards which they enforce upon their members. The Association officially has taken no steps towards the survey of hospitals or their grading, but individual members of the Association, some eight colleges now and soon to be 12 or 13 which require the interne year for graduation, have been very directly concerned in this question and have found it necessary to send out questionnaires to make investigations and to list hospitals for the use of their students, the guidance of their students, which they call approved or satisfactory, and,



incidentally, these schools have sought information, of course conspicuously from the internes who served in those institutions, and they have gathered in that way a body of information about the intimate conduct of a hospital, especially as to the personnel of its medical staff, which, so far as I know, is unique, and is of very great value, although the body of information is not large.

The Federation of State Examining Boards is an organization of the medical examining and licensing bodies of the several states of the United States. The Federation, as a body, has taken no definite action with regard to hospitals. Here again, however, certain of its member boards, in states where a fifth year is required for licensure, have been very actively concerned in securing such information. Perhaps the most conspicuous example is the medical board, the examining board of Pennsylvania. Pennsylvania has now, for three years, required that every applicant for licensure after a certain date must present evidence of having served a year in an approved hospital before he is eligible to take the examination for licensure to practice in that state. The Pennsylvania law gives this Board very large authority over those hospitals of that state, and they have been investigated very minutely and very carefully by the members of the Board, and listed. The Board has gone further than any other agency I know in specifying what are regarded the minimum essentials for an approved hospital. It even specified the number of test tubes in each laboratory and the length and diameter of the same. The New Jersey Board has investigated the hospitals of its own state in connection with the Council on Medical Education, and so a considerable body of information has been gathered there.

No reply was received from the American College of Surgeons, but I can report with regard to their activities, which is much the same as President Billings has told you, and comes direct from the Director, Dr. Bowman, in his report to us last year. The American College of Surgeons is a body of men who are engaged in surgical work. Special work including surgery in all its specialties, who have been elected to membership in that organization because, in the opinion of its Council, they are men of special training and special skill and of high ethical and moral character. It numbers now, I think, some three thousand members. It entered into the survey of hospitals some four years ago, for the primary purpose of listing those hospitals with which a surgeon



might be connected and still be eligible for membership in the organization, recognizing the fact that most of the surgical work is done in hospitals. This furnished a means of determining whether a particular surgeon was practicing under right conditions, in the right way and in an ethical manner, was free from the vice, for example, of splitting fees, but, as Dr. Billings has intimated, the college has gone much farther than this case under their investigations; they have entered into the question of equipment, of records, of staff, of conduct of hospitals, and they have, in a way, accomplished a very useful purpose in stirring up the individuals of a community as to the need of a hospital and the need of its hearty support, and they have, in that way, accomplished a great deal of good. I have not been privileged to see the detailed reports of the college on these hospitals, but they have listed a large number of institutions in various parts of the country and graded them A, B, C, similar to the grading of the American Medical Association.

Finally, the fifth medical organization in the Conference, is the American Association of Industrial Physicians and Surgeons. No direct report was received from them. It is a comparatively young organization, and, so far as I know, has not officially entered into the hospital field in the way of investigations or taking any special steps. It is of interest, however—I secured this information yesterday from Dr. Ransom—I may not be exact in my figures, but, I think something over 200 hospitals in this country are owned and conducted by industrial concerns, manufacturers or others. In a way, too, it is deserving of note that the industries which these physicians represent have a financial interest in the conduct of hospitals greater than that of almost any other group of individuals in those states where there are workmen's compensation or employers' liability acts. It means a matter of thousands and thousands of dollars whether the employees, the injured employees of the industries of that state, are taken to a properly conducted hospital of that state, manned by competent and honest men, or whether that employee falls into the hands of incompetent men who are not over scrupulous as to how much money they can gouge out of the industry. I believe, therefore, that in this movement in which we are engaged to elevate the standards of hospital practice, the industries will be among those most keenly interested and most willing to offer support of various kinds, financial and otherwise.

So much, then, for what these organizations are doing.

I think it will be obvious to you, from what has been said, that the ideas of all have been focused, first, upon some particular line of activity which concerns that organization. There have been special investigations. Second, all these organizations have seemed to agree that the first step in the betterment in the hospital situation was the taking stock of what you have got, a survey and listing of hospitals. I do not like the term "standardization," it smacks a little too much of coercion—but listing of hospitals. Now then, one of the things I should like especially to hear discussed today, and hear from the hospital superintendents here a free discussion, for you are more interested than anybody else in this, is multiple investigation from many organizations with a special purpose and a particular questionnaire, whether survey or not, is acceptable to you. Does it disturb you unduly? Do you feel that it gets results, or in your opinion would it be possible, through the medium of this conference, to combine a statement of the minimum essentials of good hospital work pertaining to organization and management and financial conduct, your especial point of view with reference to interne work and interne education, to nurses and nursing service, to social service and all that pertains to it. Would it be possible, I say, to combine a statement of minimum essentials representing all those things, in a single document, and then to send questionnaires to you once and for all, which should cover the whole field? And would it not be possible, by such a procedure as that, through the very committee which Dr. Billings has proposed, to secure a statement of the character of the several hospitals which would be acceptable to you as superintendents, to the nursing organizations and licensing bodies for nurses, from their point of view, to the medical schools, the Association of Colleges, the several state licensing Boards, in reference to interne education; an expression of opinion from you as to that point would be of very great assistance in guiding the further steps which the delegates in the Conference are to take. Personally I may say frankly that it does seem to me possible that it would be a very great desideratum. I have endeavored here now to give to you a statement of what the several medical organizations have already done in this field. Needless to say, this large mass of information which has been gathered by the American Medical Association, by the College of Surgeons, by some of the

Boards, possibly by the several colleges, is available for any further committee that seeks to bring these all together, but that it should be brought together in some central place, preferably in this library which has been so generously encouraged by the Rockefeller Foundation, does seem to me a thing to be desired.

**THE CHAIR:** The next report is concerning the Nursing Situation in America, Training Schools, Years of Nursing, Practice of Nursing, etc., by Miss Mary C. Wheeler, superintendent of the Illinois Training School for Nurses, Chicago. (Applause.)

**MISS WHEELER** presented a copy of the lengthy tabulated report of a study of the general nursing situation as made from a questionnaire sent to organizations and individuals representing a variety of interests, including those which are professional, institutional, educational, economical, social, etc.

This information complete is filed in the Hospital Library and Service Bureau of the Conference at 22 East Ontario St., Chicago, Illinois.

**THE CHAIR:** It was my privilege to receive a copy of this report made by the Committee on Nursing, and the report as presented by Miss Wheeler does not indicate to you at all the extent of the work done or the value of the information received, as necessarily the time would not permit making a full report, but the material gained will be of invaluable assistance in this hospital standardization. The report on Social Medical Service was to have been made by Dr. Edna G. Henry, who unfortunately is ill, and it will be presented by Miss Antoinette Cannon, of Philadelphia.

**MISS ANTOINETTE CANNON:** The delegates of the American Association of Hospital Social Workers were asked to make a report to the Conference on the past work of the organization and their program. Miss Henry was appointed to make the report. I am sure that she is as sorry as I am that she is not able to be here to read it in person. Her report is as follows:

The American Association of Hospital Social Workers was organized in May, 1918, at the time of the meeting of the National Conference of Social Work in Kansas City, Missouri. Previous to that time there had been three gatherings of medical social workers at which had been discussed the possibility of such organization. The question was raised by those present at the tenth anniversary of the organization of the Social Service Depart-

ment of the Massachusetts General Hospital in Boston. Again by a group called together by the Social Service Department of Indiana University when the Conference of Social Work met in Indianapolis in 1916, and was again discussed at the Conference of Social Work in Pittsburgh in 1917. Many of those present upon these three occasions desired immediate organization, but the majority felt that the time was not ripe for it. By May, 1917, it became increasingly evident that an association should be formed at once. While such organization would be made difficult necessarily by the inroads the War had made among social workers, this very fact argued still more for the creation of an immediate organization.

The original purpose of the Association was, "to serve as an organization of intercommunication among hospital social workers, to maintain and improve standards of social work in hospitals and dispensaries, and to stimulate its intensive and extensive development."

The organization was simple. It consisted of six officers,—president, three vice-presidents, a secretary and a treasurer,—of an advisory council of fifteen members, and of four types of members, executive committee of ten members—active, associate, contributing and sustaining.

At the time of organization the Association decided to hold its annual meetings with the National Conference of Social Work, but to attempt to have also a semi-annual meeting with the National Nursing Association, the American Hospital Association or some other medical body. It made this decision because it felt that the first emphasis had been placed rather upon the medical aspect of the work than upon the necessity for social knowledge.

The Association since its organization has had four meetings. After the initial Kansas City meeting, it had its first annual meeting in Atlantic City, June, 1919, and its second in New Orleans in April, 1920. It has held only one other meeting thus far, that with the American Hospital Association in Atlantic City, September, 1918; but now plans another in Montreal, Canada, in October, 1920.

The Association felt immediately that in order to further its announced purposes it should, at the earliest possible date, have a journal or medium of publication and an executive secretary. These could carry from department to department and from community to community news of whatever had been found good or proved undesirable. The Association also felt that its ultimate success and perfected usefulness would depend largely

upon its ability to obtain or to train well-equipped women.

While the Association as such has taken no steps toward securing the training of such workers, it did release its first executive secretary to serve on the faculty of Smith College during the first year it offered a course of training for medical social workers, while its first president is teaching medical social work in Indiana University, and almost all of the officers of the Association have as individuals been connected with the teaching of social work in practically all of the established schools where such courses are being given. The enlistment of new workers and the encouragement of suitable training for them must be one of the Association's urgent concerns in the immediate future.

An executive secretary and a publication, however, meant money, and even more than money, the interest of all medical social workers. So during the first year the chief effort of the Association was to increase its membership. It now has six hundred sixty-nine members and actively represents two hundred eighty-eight social service departments.

In August, 1919, however, the Association began the regular issue of a four-page monthly Bulletin, which it is still publishing. This Bulletin may be obtained by other subscribers than members of the Association, but it serves as a medium of communication among all interested departments. It gives news of the meetings of the Association, interesting bits of information about new work and related subjects, and keeps the departments informed concerning each other. This Bulletin already is one of the valuable assets of the Association.

During the first year also the secretary of the Association published a Directory then complete, which since has been revised from month to month by changes reported in the Bulletin. This Directory alone represents rather fully the strength of the new organization, and has been of great use to subscribing members.

The finances of the Association did not permit it, however, to employ a full-time executive secretary or to provide much money for traveling expenses. It did, however, employ its own secretary, Miss M. Antoinette Cannon, as a half-time executive secretary. She served from the beginning until July, 1920, and to her is due entirely the success of the Directory, the continuance of the Bulletin

and such information service and consultation as the Association has had. Her work was so successful that the Association is more determined than ever to employ an executive secretary the moment it can raise enough money to do so. More than anything else the Association feels the need for a closer and more permanent relationship between existing departments and for a better information service. It also needs more literature, literature which is difficult to obtain from busy workers. Only an executive secretary could meet these needs.

For the two years of its existence the Association has achieved much in interesting the majority of the best medical social workers in the country in building up its own membership and in outlining its plans for the future. There is no doubt among its leaders, however, that its biggest accomplishment has been the creation in its own body of a spirit of open-mindedness and power of adaptation and a thirst for knowledge which makes it, small as it is, one of the most remarkable of the groups interested either in public health, modern medicine or the improvement of social work. Its tendency is at all times to act generously and without criticism, to affiliate itself, although it may not always be able to give much help, with every large movement which desires the accomplishment of any of its own purposes. It holds its meetings with the largest social and medical groups because it believes that this is the best way both to educate its own members and to express its desire for honest cooperation.

While as an Association it has done practically no public work, its officers and members have been conspicuously interested in many activities. Its secretary took an active part in Americanization work. It is a part of the new American Conference on Hospital Service. One of its delegates is a member of its board. Its present secretary has had much to do with the establishment of medical social work in the United States public health hospitals, while its first president was four months in the Surgeon General's office, organizing medical social work in the military hospitals. Various members of the Association have served on committees on Family Welfare, Delinquency, Health and Mental Hygiene, and given valuable service to the National Red Cross. Officers of the Association and the members of its executive committee have taken many opportunities to contribute to journals, papers and meetings, although it is the constant com-



plaint of its executive committee that the members of the Association do not do enough of this.

While such members often have thus offered helpful conclusions drawn from their own work which might aid that of others, they have far more often borrowed ideas from older social workers and from medical men which have helped them. For instance, the Association is officially represented on the committee now making a survey of medical social service departments for the American Hospital Association. They are officially lending assistance in an attempt to make this survey helpful, while individual heads of departments are doing all they can to cooperate with the committee. Without such co-operation from the heads of departments such a survey could not be made successfully. Members of the Association have been wise enough to see, however, that any bit of knowledge so gained must react favorably for their own purpose.

For the next year the Association is considering a re-writing of its constitution which might bring a different districting and larger membership, and better financial standing. It hopes before the year is out, to employ a full-time executive secretary, to enlarge its membership and to increase its publicity. Even before it does this, however, it will make, through its Bulletin and secretary, a greater and greater effort in every possible way to bring various departments and its members closer together. It knows that there are many remarkable little bits of work going forward with which all departments should become acquainted. It believes that it can not serve effectively without remembering that its own work is equally allied to the larger medical and larger social purposes of which it is a part. It believes that by constant attention to this fact it will give finer results than it can by independent action.

It is equally certain that it has found in itself a way by which the new science of Sociology may be used by medicine even as all other sciences have been used, and equally a way in which Sociology through it may increase its own knowledge. But this cannot be done unless the members of the Association are increasingly trained and better trained along medico-social lines, and are made more conscious of their real purpose,—that of furthering the care and cure of patients, of serving physicians socially and of indirectly educating communities.

*Officers—1918-1919.*

President—Edna G. Henry, Director, Indiana University Social Service Dept., Indianapolis, Ind.

First Vice-president—Ida M. Cannon, Chief of Social Service, Massachusetts General Hospital, Boston, Mass.

Second Vice-president—Mary E. Wadley, Bellevue Hospital, New York City.

Third Vice-president—Louise Morrow, Social Service Dept., University Hospital, San Francisco, Cal.

Secretary—M. Antoinette Cannon, Social Service Dept., University of Pa. Hospital, Philadelphia, Pa.

Treasurer—Margaret S. Brogden, Social Service Dept., Johns Hopkins Hospital, Baltimore, Md.

*Officers—1919-1920.*

President—Edna G. Henry, Director, Indiana University Social Service Dept., Indianapolis, Ind.

First Vice-president—Kate McMahon, Social Service Dept., Boston Dispensary, Boston, Mass.

Second Vice-president—Mary E. Wadley, Bellevue Hospital, New York City.

Third Vice-president—Louise Morrow, Social Service Dept., University Hospital, San Francisco, Cal.

Secretary—M. Antoinette Cannon, Social Service Dept., University of Pa. Hospital, Philadelphia, Pa.

Treasurer—Harriet Gage, Institute for Juvenile Research, Chicago, Ill.

*Officers—1920-1921.*

President—Ida M. Cannon, Chief of Social Service, Massachusetts General Hospital, Boston, Mass.

First Vice-president—Kate McMahon, Social Service Dept., Boston Dispensary, Boston, Mass.

Second Vice-president—Suzie Lyons, Social Service Dept., Johns Hopkins Hospital, Baltimore, Md.

Third Vice-president—Louise Pond, Social Service Department, Brooklyn Hospital, Brooklyn, N. Y.

Secretary—Ruth V. Emerson, Director Bureau of Medical Social Service, Natl. Hdqtrs., American Red Cross, Washington, D. C.

Treasurer—Harriet Gage, Institute for Juvenile Research, Chicago, Ill.

THE CHAIR: May I ask the pleasure of the Conference? These reports are all open to discussion, and, as I said to you earlier in the meeting, we would like to have your opinion about the suggested principles and policies for the

conduct of the Conference in the work of the Board of Trustees. To take the initiative on that, I would like to ask you to discuss whatever part of the program you please. There is much food for discussion in the reports made by me as President, by Dr. Dodson and Miss Wheeler and the reports on the nursing situation, especially, but we will not have time to take up all of them. The matter of the Conference as to its principles and policies is, to us, the most important thing at the present time. Therefore may I ask you to speak upon any of those that you choose, especially upon principles and policies?

DR. WASHBURN: This is a happy day for hospitals, when the different organizations get together in the manner which is suggested and now well under way in conference, so that we can have unity of effort. I predict that when this is well under way we shall wonder how we ever went 22 years without it. There has been great waste of effort. Dr. Dodson asked one question, if I understood him correctly, in which he wished the opinion of the members of this organization as to whether or not it was advisable that the hospital survey should be made under the direction of this Conference rather than by the different bodies separately. It seems to me there is only one possible answer to that. We have all of us appreciated what the American College of Surgeons is doing, but I think every one of us thought, when it was first broached, that it represented a survey of only a part of the organization of the hospital. We took it, because they had the money and were able to do it, and we wanted it to be done, but it is very much better that it should be done under the auspices of the united bodies which represent the component parts of the hospital. Now there is one thing which has not been brought out, Mr. President; how are we going to get the Trustees into this thing? They are the most ignorant part of the whole hospital. Now the Trustees of hospitals are eligible to membership in the American Hospital Association. As far as I know, that is the only one of the Associations to which they are eligible. There may be others, but if there are, I am not aware of it. How are we going to get them in and get them interested? Some of them assume a very superior attitude towards this organization and rather intimate, although they do not dare say it, that it is nothing but an organization of superintendents who are interested in keeping things as they are and that is about all there is

to it. Now, how are we going to educate this body of men? I ask you the question. I cannot answer it. I was a little surprised, Mr. President, that in your paper, when you spoke of the two main principles of a hospital, as I recall it, the first one was the care of the sick and the second one was the establishment of a health center. Those are the two, are they not? I was a little surprised that you did not make one of your primary principles education, although I saw from your line of reasoning that you felt medical education was limited to only a fraction of the hospital and did not apply to all, but some form of education applies to all hospitals, if it is only the education of the community. In that great letter to which reference was made yesterday by one of the speakers, sent out in 1710 by Jules Jackson, of Boston, to establish the Massachusetts General Hospital, the two objects, as given for the hospital were these; first of all, a proper place in which the sick of the community could be cared for and restored to a state of health; and, second, a place where a young man could study medicine and obtain the laboratory work as well as the theoretical teaching. Up to that time they had been obliged to go abroad or to Philadelphia. It would seem to me, sir, I do not know how essential it is, that you might consider adding education as the third principle that applies to all hospitals.

EX-PRESIDENT ANCKER: Never before in my career as a member of this organization have I so deplored my inability to express my mind and thoughts in public. I am one of those unfortunate persons that are always ill at ease and present so bad a front as I do when I do what I am doing now; but this is a subject in which I am so much interested, and I have had so much experience with it, that I cannot refrain from at least saying something on the subject. First, I want everybody to know that I am enthusiastically and ardently in favor of hospital standardization. But if you are going very far with it, I have been taught to believe, after a long career in the hospitals, that the standardization of hospitals must begin with the education of the members of the staff, with the doctor himself. To begin with, there is no such thing possible as the standardization of a hospital without the organization of the staff. I am an enthusiast in the matter of the educational functions of a hospital. What a deplorable thing it would be if such an institution as ours, with its wealth of material and 800 beds, where we care for every disease that is known or ordinarily met with in

the United States—that they should go to waste and not be used for the education of the students and the nurses. I have very recently asked Mr. Bowman to send a copy of that minimum of standardization to every member of my Staff and I had my Secretary give their addresses. Try to educate them and you will have no trouble in standardizing hospitals. I think the average trustee wants them standardized. I do not know of a superintendent that does not want it, but it can't be done your way. Last year some member of this body made the remark that he thought a hospital had three functions. The first was the education of the doctor, the second was the training of the nurse and the last was the treatment of the patient. Now I do not believe that; I believe that the first and primary object of any hospital is the proper care and treatment of the patient.

THE CHAIR: In announcing Principle one, it has in view the adequate treatment of the patient as the chief obligation of a hospital. There are thousands of hospitals in the country of less than 100 beds, too many of which, the majority, do not give adequate treatment to the patient. Wherever the fault may lie, with trustees, superintendents, if they have one, staff, nursing or what-not, or lack of laboratories, it is still there.

The great object of all the agencies which are engaged in hospital betterment is not to apply it to the Massachusetts General, to the Presbyterian Hospital in Chicago, or any other good one there, or to Johns Hopkins Hospital, to the University of Pennsylvania Hospital, or any other good hospital in the country. If there was no more need of betterment than to be applied to those institutions, there would not be any need of a conference of this kind, but it is to aid the thousands of small hospitals all over this country, to show them a way for adequate treatment and the application of the minimum essential to the betterment of the hospital to give adequate treatment to the patient—that is the main problem before us. There is no one who appreciates and believes in the educational principle of the hospital more than myself; I have preached it for years, and I have said in my paper that one must look toward that and that the hospital shall be an educational institution in every function of the hospital to its own personnel. They cannot be the center of medical education, nor can they take the place of the medical schools. The time may come when we may have our students taught extra-murally and send them to such places, but

adequate treatment of the patient is the chief obligation of the hospital.

DR. SMITH, of Johns Hopkins: I really rise only to express, as Dr. Washburn did, my gratification that the time has come when apparently we are all to get together and try to work out a constructive program for the betterment of hospital conditions, in order that we may better meet the ever-growing demands made upon hospitals. I think it is particularly gratifying that the work of the hospital conference has begun, under such able leadership, to have the sympathy and the time and constructive ability of one who has, for so many years, been a leader in medical education and in high standards of clinical practice, as our President. To answer Dr. Dodson's question, I think there is no argument that it is better to have the program carried out under the direction of the combined bodies as represented in the Conference. Undoubtedly much good has resulted from individual efforts, but it seems to me that it is possible to develop a constructive program under an organization of combined membership representing all or most of the different interests, and that it is much more possible to get constructive results under such a program than as the result of individual and uncoordinated efforts of various organizations. I would like, however, in that connection, to mention the possibility of making use of efforts which are being made by two individual committees which it seems to me are better qualified to conduct the investigations in which they are engaged than any committee of this Conference at this time, for the following reasons; first, because the scope of the work is so great that it requires financial backing. Now, I refer to the committee appointed by the Rockefeller Foundation to conduct an investigation into the ways and means of improving the standards of hospital administration and the training of hospital administrators, and the second committee, also a committee financed and backed by the Rockefeller Foundation, engaged in making a study of the various phases of the education of the nurse, the needs of various types of nursing, such as public health nursing, private nursing, etc. I believe, because of the scope of the work involved, the fact that financiers have been provided so that competent investigators can give their full time to the work, that those committees are in position to do the work better than it can be done without the financial backing which I understand the Conference has not now available for such work. With those



two suggestions, that the result of those committees might well be awaited by the Committee of the Conference and their recommendations taken under consideration when presented, I heartily endorse the suggestion made by Dr. Dodson that the Conference is the better organization to conduct the investigation. Now, as to the questionnaire method, I am frank to say that I have not very much use for questionnaires. It is a useful means of collecting data for reference, but I have been unable to think, as I have been going over the matter in my mind, of any real constructive program that has come out of a questionnaire investigation, if it was conducted only by questionnaires. I think it needs something more. There is just one more thought, if I am not taking too long, that I would like to throw out as a suggestion to the Committee. The shortage of nurses apparently has been very much on the minds of everyone. The particular phase that I wish to speak of is the shortage, not in the training schools, but the shortage, at the present time, of graduate nurses. Dr. Ancker spoke of the education of the Staff. I wish to refer to the cooperation of the profession. It seems to me that if there is such a real shortage of graduate nurses, it is highly important that we arrive at some more intelligent method of utilizing the services of those who have been specially trained. Now I refer particularly to the custom that prevails in most hospitals—it does in mine, and it hurts me to see, day after day, women who have spent three years in acquiring a special knowledge, pushing wheel-chairs up and down a bridge, spending their time brushing the hair and reading to people who can afford to pay for their services but who really do not require the services of a special nurse, and it seems to me that we ought to consider ways and means of conserving our resources in this respect, and it can be done if we have the cooperation of the profession and of the members of the staff in our hospitals.

MR. RICHARD BORDEN: I think that the remarks of Dr. Washburn and of the President have given me some excuse for taking the floor. Perhaps I may have taken it too often; trustees are ignorant and need education, but perhaps one exhibition of that ignorance is pride in their institutions, and through that weakness, education can be most quickly accomplished by the investigations which are made for the purpose of standardizing hospitals. Whenever you come to a hospital with a competent investigator, look through the field of its work and find this thing criti-

cized and make it known to the trustees of that hospital that their hospital is not up-to-date, that it is carrying the work on through a wrong method, you have immediately educated those trustees not only in the desirability of improving their hospitals, but in the desirability of having a competent examination of their methods of doing business made from time to time, so that they will know what the needs of the institution are and be prepared to improve them. There has been nothing that I know of that has so stimulated the interest of the trustees and so improved the general atmosphere of the hospitals through the country, as the standardization, minimum standard of hospitals, which has been carried into effect by the initiative of the College of Surgeons. Now the question today is as to the policy which should be pursued in the future. I think there should be a regular and constant examination of the hospitals in the country by competent investigators, with reports to some general body as to the result, with a listing of the hospitals based on those results, with information to the trustees as to the needs of the hospitals; that that examination should be made by a central body; that it should include the principal part of hospital administration, hospital work, which means administration, medical service, nursing service, and in administration is included, as an important part, the social service work; that all these organizations interested in that sort of work should authorize some central committee to determine on what the requirements of a hospital should be, to procure a corps of investigators competent to examine the hospitals personally, not through questionnaires, because there are two difficulties with questionnaires, one is that a lot of them are not answered, the other is that a lot of them are not answered intelligently. If questionnaires are established, they should be carried around in the pockets of the investigators and answers should be obtained on the field in accordance, not with the word of the person who answers them, but in accordance with an examination of the facts, and it seems to me that it would be quite competent for this organization today to make a resolution that it is most desirable in the interests of the hospitals and those they serve, that through some competent central body representing the various interests, there should be a constant progressive and continuous record by examination of the status and requirements of the hospitals of the country. One of the things which Dr. Billings has said is the primary func-

tion of the hospital, is the welfare of the patient, and I want to say that I believe that the requirement of the College of Surgeons that there shall be monthly clinical meetings of the staff, has done more for the benefit of the patient than almost any other single thing that could be accomplished; and with all their ignorance, trustees have felt that it was desirable that the members of the medical staff should make the examinations of their work from time to time, but the medical staff know that the trustees are ignorant, and when we say it ought to be done, they pay no attention to it, but when the College of Surgeons says it ought to be done, why, it must be done.

A MEMBER: Just a plea for the Trustees. I have attended the conventions of the Hospital Association and the Nurses Association, and I have yet to hear the first hearty invitation for the Trustees to attend. Admitting that the trustees of an institution are the ignorant part of that institution, I wonder if a way cannot be found to educate the trustees, to help them in becoming more helpful to the management of the institution, by its scientific people? The very fact that there are trustees means that there is interest, to begin with. Yesterday a section was organized; there were perhaps half a dozen present, a section to be known as the trustees' section, and I sincerely hope that all those who are here today are interested in the education of the trustees and will help to form some constructive program for next year. I am thankful that a kind word was said for the smaller hospitals, because, after all, we need the smaller hospitals, we need them throughout the country. When we realize that in our country, the United States, when we realize that out of sixteen of the largest countries in the world, the United States stands third in the mortality of mothers, then we begin to feel that something is wrong and that it is necessary for the public at large to become interested in the problem somehow, and I feel that it is only through the smaller hospitals that we can accomplish the greatest amount of good, because we know that there are more mothers dying in the rural districts than anywhere else. Now then, could not a way be found to make it interesting for the trustees, so that the trustees would really want to come to these conventions? But year after year we hear that the trustees are the ignorant part of the institution. I have had the opportunity of working with men and women who are the trustees of an institution, and I think that if some of these superintendents and hospital people

could see how they labor, well, until one and two in the morning, sometimes, in order to make it possible that there should be a health center in their community, that perhaps they would feel a little more kindly toward the trustees of the institution.

MRS. McCARTER: I am speaking as a trustee, and I would like to say that in my hospital, at Long Branch, N. J., I went to the chief of staff on the subject of standardization, and they are very anxious to put it in, and in the absence of the President it came up to me to put it through, and he said, "You don't know anything about it, the Board of Governors don't know anything about it." I said, "Well, that is true." I am also chairman of the training school, and Miss Eldredge came down to speak to us and she said that all the Board of Governors ought to come to these meetings and learn something about what the nurses are doing. I think they are both quite right, and I think when a thing is brought properly to a trustee, that she or he can take it back and teach others, as I have learned a great deal at this meeting.

Adjourned.

## AMERICAN HOSPITAL ASSOCIATION

### TWENTY-SECOND ANNUAL CONFERENCE

Montreal, October 8, 1920, 2 P. M.

President Howland in the Chair.

THE CHAIR: The meeting will please come to order. I would remind you that the order of business this afternoon is, first, unfinished business, second, reports of committees; third, election of officers. Unfinished business, as I interpret it, means something already begun. New business would not be in place in this session. Is there any unfinished business? If not, then the next business will be reports of committees. We will have, first, the report of the Auditing Committee.

DR. MOSS: Mr. President, ladies and gentlemen: We have a very short report. We have examined the report of the audit of the finances of the American Hospital Association, as prepared by Arthur Young & Co., certified public accountants, of New York and Chicago, and find them entirely satisfactory, for the period November 1, 1919, to August 31, 1920.

October 8, 1920.

We hereby certify that we have examined the report of the audit of the finances of the American Hospital Association, prepared by Arthur Young & Co., certified public accountants, of New York and Chicago, and find them entirely satisfactory for the period from November 1, 1919, to August 31, 1920.

A. J. Moss, M.D.,  
Chairman, Audit Committee.

It was moved and carried that the report of the Auditing Committee be accepted and placed on file.

THE CHAIR: The next committee to report is the Committee on Legislation. Major Haywood will make the report.

### REPORT OF THE LEGISLATIVE COMMITTEE

Legislation relating to hospitals, which has been enacted by Federal or State governments during the last year, has been reported in the hospital magazines.

Your Committee feels that with the legislative machinery as now provided for by the Constitution, the members of this Association cannot be kept in touch, as they should be, by bulletins or otherwise, with legislative matters which should be acted upon by the Association before they become laws.

The American Hospital Association can become so powerful through efficient organization that the weight of its opinion will be respected by Federal and State governments.

Your Committee recommends:

That a Legislative Service Bureau be established as soon as it may be accomplished, such Bureau to be under the control of the Trustees and in immediate charge of a director, and that thereupon the Legislative Committee, as now provided for by the Constitution, be abolished.

W. G. NEALLY,  
A. K. HAYWOOD.

THE CHAIR: I would call attention to the fact that this committee calls for a change in the present constitution and by-laws because, under the present constitution and by-laws the Committee on Legislation is appointed by the President. Now, as I understand it, and I hope somebody from the floor will correct me if I am mistaken, any change in the constitution and by-laws must be presented at one session and acted on at a subsequent session. There is no subsequent session of this present conference; there-



fore, as I understand it, the recommendation could not be acted on this afternoon. Am I correct? Mr. Richard Borden.

MR. RICHARD BORDEN: As I understand it, the recommendation is that the constitution be amended as soon as it becomes possible to form a legislative bureau. There is one thing I want you who are here to carry home to your trustees, and that is, that one of the most important things that this organization can effect in the interests of the economy of hospitals and the proper running of hospitals, is a legislative bureau; but in order that the legislature may become efficient, it means a competent director. We cannot get one unless we pay him an adequate salary, and we cannot pay him that salary unless your hospitals become institutional members and contribute the money. I think if they do so, they will get the full benefit of that money, and I think it is quite proper at this meeting, and I so move that the report be accepted and filed.

The motion was seconded and adopted.

THE CHAIR: The next committee to report is the Committee appointed at this conference to report on the address of the President and the Report of the Trustees and of the executive Secretary. Is that Committee ready to report?

To the American Hospital Association:

The undersigned, members of the committee to which was assigned the President's Address, Report of the Trustees and Report of the Executive Secretary, for the purpose of making such recommendations concerning the same as they deemed advisable, would respectfully report as follows:

(1) We endorse the effort to establish a connectional relation between the American Hospital Association and the various State and Province associations. We recommend that a special effort be made during the coming year to organize the entire country on that basis. We call attention to the fact that while the plan suggested by the Trustees provides for joint personal memberships, it does not cover the question of joint institutional memberships, and we believe that the one is as desirable as the other. We also concur in the suggestion that a form of Associate Institutional Membership would be valuable.

(2) We congratulate the officers upon the work already accomplished through special Service Bureaus. These should be added to as rapidly as needs are suggested and



funds allow. We recommend that hospital boards call upon the Association for assistance in helping solve their local problems. Only as this is done will the value of institutional membership be appreciated, and it is also essential as indicating to the officials of the Association the directions in which the work should be developed. Not only should assistance be asked from the Association, but members should furnish to the Association material and information which has been found helpful to them. A satisfactory Reference Library cannot be built up by one-sided efforts. Through these Service Bureaus the American Hospital Association should be the clearing house for hospital information.

(3) Realizing that autopsies serve as a great check on the efficiency of hospital work and that they add much to medical science, we commend the suggestion that hospital officials endeavor to increase the number secured.

(4) The reference to the House of Delegates plan of organization is very appropriate at this time. When the majority of states and provinces shall have affiliated with the American Hospital Association, it is probable that some plan of representative business control will be advisable. This can easily be secured when these connectional relationships have been established. However, care should be taken, when the time comes to make a change, that sufficient study is given the matter so that the Association will be strengthened rather than weakened.

M. T. MACEACHERN, Vancouver, B. C.

D. W. SPRINGER, Ann Arbor, Mich.

MRS. EITEL.

DAISY C. KINGSTON, Fremont, Ohio.

C. W. MUNGER, Milwaukee, Wis.

DR. MACEACHERN: This report is signed by the various members of the Committee, and I move that the Association pass these on to the Board of Trustees with full power to act on them.

The motion was seconded and adopted.

THE CHAIR: The next committee to report is the Committee on Time and Place of the next meeting.

#### REPORT OF THE COMMITTEE ON TIME AND PLACE

The committee has reviewed the invitations received and heard the delegations from various cities. The committee finds that the following cities apparently have the proper facilities to handle the convention of next year: New York, New Orleans, Milwaukee, and Minneapolis.

The committee recommends that the applications of these four cities be referred to the trustees with power to act, that the trustees may have an opportunity to further investigate the physical accommodations for the Convention in these cities and have proper opportunity to give careful consideration to any factors or any influence which the meeting next year may have upon the general welfare and progress of the Association.

MARY L. KEITH,  
H. C. GOODWIN.  
A. R. WARNER.

THE CHAIR: You have heard the report of the Committee on Time and Place. What is your pleasure?

DR. WILLIAM H. WALSH: I think the proposition of referring the matter to the Board of Trustees is excellent. There are a great many considerations at the present time with regard to the meeting of this Association, which must be very carefully considered, and I therefore think that the plan of having the trustees decide the matter is well taken. I therefore move that the report be accepted and that the decision be left with the Board of Trustees.

Motion seconded.

MR. DANIEL TEST: Before that motion is put; they called this the Committee on Time and Place. There is nothing said about the time. I wonder whether that omission is of purpose?

THE CHAIR: What has the Committee to say as to time?

CHAIRMAN OF COMMITTEE: It would seem as though the time could not be arranged until the place was arranged, on account of climatic conditions. If you are going to New Orleans, it would be one thing; if you are going to Milwaukee, it would be another.

THE CHAIR: I understand, Dr. Walsh, that your motion includes both.

DR. WALSH: Both.

MR. SMITH, of Baltimore: Do I understand that the trustees are limited in their consideration to the cities the names of which were read?

THE CHAIR: I would so take it. Will the Committee please instruct us on that?

CHAIRMAN OF THE COMMITTEE: That was a suggestion, merely a suggestion; those four cities.

THE CHAIR: But that is to be left entirely in their hands?

CHAIRMAN OF THE COMMITTEE: Yes, anything that is of benefit to the organization, the trustees will pass upon as they see fit.

THE CHAIR: Is that your understanding, Dr. Walsh?

DR. WALSH: Yes, as I understand it, the Committee has reviewed invitations that have been officially received. If any other members on the floor have any places to suggest to the trustees, that would be included, because they would look these over with the same care they did the ones the Committee looked over.

MR. TEST: I do not quite like the report of the Committee with this new interpretation. If they are going to mention these four places, I quite approve of it. If they are going to leave the whole thing open, I do not like the statement that they have had invitations from four cities which can afford the accommodations. There happens to be an invitation from Philadelphia, from the officials. I passed it on, because I did not think the convention should go there next year; but if the thing is to be passed on, I do not think it ought to be confined to those four cities.

THE CHAIR: Will it be satisfactory if that is just passed on to the trustees and Philadelphia included?

MR. TEST: I am satisfied.

THE CHAIR: The motion, then, is that the matter be just left to the Board of Trustees.

The motion was adopted.

THE CHAIR: The next committee to report is the Committee on Gauze.

The American Hospital Association:

Your committee to which was referred the matter of surplus gauze donated to the hospitals of the United States by the American Red Cross begs to report, that it has gone over the correspondence between the American Hospital Association and the American Red Cross, and that the matter is closed so far as further distributions are concerned, as the Red Cross has no more surplus gauze.

It would appear that not quite half the amount anticipated has been distributed, but your Committee feels that nothing can be accomplished by trying to place the responsibility for this decrease, and any attempts to do so would probably lead to still further misunderstandings.

The Hospital Association received a handsome gift from

the Red Cross and your Committee is sure that your feeling is one of appreciation.

DANIEL D. TEST,  
JOHN M. PETERS,  
Committee.

Motion was made that the report of the Committee on Gauze be accepted and placed on file. Motion seconded and passed.

THE CHAIR: The next committee to report is the Committee on Nominations. Is that Committee ready to report?

The American Hospital Association:

Your Committee on Nominations has given careful consideration to the object of their appointment and are united in proposing the following names:

For President-Elect, Dr. George O'Hanlon, Bellevue Hospital, New York City.

First Vice-President, Dr. M. T. MacEachern, Vancouver General Hospital, Vancouver, B. C.

Second Vice-President, S. G. Davidson, Youngstown General Hospital, Youngstown, Ohio.

Third Vice-President, Miss Alice M. Gagggs, J. N. Norton Memorial Infirmary, Louisville, Ky.

Trustees: Dr. Louis H. Burlingham, Barnes Memorial Hospital, St. Louis, Mo., to fill the vacancy caused by the resignation of Dr. A. R. Warner; Miss Mary H. Riddle, Newton Hospital, Newton Lower Falls, Mass.; and Mr. H. E. Webster, Royal Victoria Hospital, Montreal, Canada, to serve for the regular term of three years.

Treasurer, Mr. Asa Bacon, Presbyterian Hospital, Chicago.

DANIEL D. TEST.  
EUGENIA D. AYERS.  
CHARLES H. YOUNG.

MR. TEST: I have been requested to make two observations for the Committee. When there were three trustees, we had one woman. There are now six trustees appointed, and it was the feeling of the Committee that there should be two women on the Board. It did not seem that this was the time to make that change, however, for the following reason: Dr. Burlingham was elected last year for the short term of one year. When the increase was made, it seemed only right and proper, and I am sure that every member of the Association will approve it, that he should be elected to the two year

term, so that he would serve the regular three years. That left the two vacancies for the three year appointments, and the Committee felt that to nominate one woman and one man would be a proper procedure. We are just dropping this as a suggestion for the Committee next year. The other observation is this: The members of the Committee have heard, this last week, the word precedent a good many times. I suppose that the danger of all organizations is falling into precedents; it is a dangerous thing, and the longer a precedent is followed, the more firmly it is entrenched, so that this Committee earnestly suggests that the American Hospital Association absolutely keep away from precedent as the only sure way for real progress.

THE CHAIR: You have heard the report of the Committee on Nominations. I would remind you that by our Constitution and By-Laws the officers for the coming years are to be elected by ballot.

DR. WASHBURN: I move that the Secretary be instructed to cast one ballot for the nominees as presented.

The motion was seconded and unanimously adopted and the ballot cast in accordance therewith.

President-Elect O'Hanlon was escorted to the platform and greeted with applause.

A motion was made by Dr. George O'Hanlon, expressing the thanks of the Association for the efforts made by the members of the Local Committee and the City of Montreal in behalf of the Association in the arrangements for the conference then closing. This motion was adopted by rising vote.

PRESIDENT-ELECT O'HANLON: A motion to adjourn is now in order.

On motion, the Convention then adjourned.

## INSTITUTIONAL MEMBERSHIP OF THE AMERICAN HOSPITAL ASSOCIATION

### ALABAMA

The Moody Hospital, Dotham, Miss., Ida S. Inscar, superintendent.

### CALIFORNIA

Methodist Hospital of Southern California, Los Angeles, Miss Ida May Wood, superintendent.

The Samuel Merritt Hospital, Oakland, Mr. H. S. Hudd, superintendent.

Scotia Hospital, Scotia, Dr. E. L. Cottrell, superintendent.

South San Francisco Hospital, South San Francisco, Mr. M. Belle, superintendent.

University of California Medical School and Hospitals, San Francisco, Dr. W. E. Musgrave, superintendent.

Florence M. Ward Sanatorium, San Francisco, Miss Irene M. Ferguson, superintendent.

### COLORADO

Park Avenue Hospital, Denver, Mr. H. Lamborn, superintendent.

Presbyterian Hospital of Colorado, Denver, Mr. Pliny O. Clark, superintendent.

University Hospital, Boulder, Miss Martha M. Russell, superintendent.

### CONNECTICUT

Grace Hospital, New Haven, Mr. J. Alison Hunter, superintendent.

Greenwich Hospital, Greenwich, Miss Edith P. Whicher, superintendent.

Lawrence & Memorial Associated Hospitals, New London, Miss K. M. Prindiville, superintendent.

The St. Mary's Hospital, Waterbury, Sister Mary Xavier, superintendent.

### FLORIDA

Miami City Hospital, Miami, Mr. John L. North, superintendent.

### GEORGIA

City Hospital, Columbus, Miss Maud L. Way, superintendent.

The Macon Hospital, Macon, Mr. L. C. Brown, superintendent.



University Hospital, Augusta, Dr. W. P. Morrill, superintendent.

#### ILLINOIS

Brokaw Hospital, Bloomington, Miss L. J. Justis, R.N., superintendent.

Julia E. Burnham Hospital, Champaign, Miss Aurilla J. Perry, superintendent.

Central Free Dispensary, Chicago, Mr. Homer F. Sanger, superintendent.

Englewood Hospital, Chicago, Dr. E. T. Olsen, superintendent.

German Evangelical Deaconess Hospital, Chicago, Rev. F. Weber, superintendent.

Jarman Memorial Hospital, Tuscola, Mrs. Elizabeth M. Guyton, R.N., superintendent.

Mercy Hospital, Chicago, Sister Mary Rita, superintendent.

Michael Reese Dispensary, Chicago, Mr. John E. Ransom, superintendent.

Michael Reese Hospital, Chicago, Dr. Herman Smith, superintendent.

Norwegian American Hospital, Chicago, Miss Bella Olsen, superintendent.

The Olney Sanitarium, Olney, Miss Katharina Weber, superintendent.

The Passavant Memorial Hospital, Chicago, Miss Charlotte Christian, superintendent.

The Presbyterian Hospital of the City of Chicago, Mr. Asa S. Bacon, superintendent.

Provident Hospital & Training School, Chicago, Miss Evelyn M. Kimmell, superintendent.

St. Luke's Hospital, Chicago, Mr. Chas. A. Wardell, superintendent.

Sherman Hospital, Elgin, Miss C. Irene Oberg, superintendent.

South Chicago Hospital, Chicago, Miss Gertrude A. Briggs, R.N., superintendent.

Mary Thompson Hospital, Chicago, Miss Virginia P. Best, superintendent.

Washington Park Hospital, Chicago, Dr. C. O. Young, superintendent.

The West Suburban Hospital Association, Oak Park, Mr. E. J. Hockaday, superintendent.

#### INDIANA

Elkhart General Hospital, Elkhart, Miss Svea Landh, R.N., superintendent.

Protestant Deaconess Hospital, Evansville, Sister Carolina Braun, superintendent.

Robert W. Long Hospital, Indianapolis, Mr. Robert E. Neff, superintendent.

The Walker Hospital, Evansville, Dr. James Y. Welborn, superintendent.

#### IOWA

Des Moines General Hospital, Des Moines, Mr. F. J. Trenery, superintendent.

W. G. Graham Hospital, Keokuk, Miss Mary C. Jackson, superintendent.

Iowa Methodist Hospital, Des Moines, Mr. Cecil C. Hurin, superintendent.

St. Luke's Hospital, Davenport, Miss Martha Baker, superintendent.

Washington County Hospital, Washington, Miss Elizabeth Finlay, superintendent.

#### KANSAS

Arkansas City Hospital, Arkansas City, Mr. R. Claude Young, superintendent.

Brinkley-Jones Hospital (Inc.) and Training School for Nurses, Milford, Miss Gertrude W. Johnston, superintendent.

The Halstead Hospital, Halstead, Mr. L. P. Krehbiel, superintendent.

Hatcher Hospital, Wellington, Mr. A. R. Hatcher, superintendent.

The Hutchinson Methodist Hospital, Hutchinson, Mrs. Charlotte Briggs, R.N., superintendent.

Mercy Hospital, Fort Scott, Mother Mary, superintendent.

#### KENTUCKY

Louisville City Hospital, Louisville, Dr. Henry Enos Tuley, superintendent.

Norton Memorial Infirmary, Louisville, Miss Alice M. Gags, superintendent.

#### LOUISIANA

Charity Hospital of Louisiana, New Orleans, Dr. S. W. Stafford, superintendent.

The North Louisiana Sanitarium, Shreveport, Mr. Louis Abramson, superintendent.

The Presbyterian Hospital of New Orleans, Miss Julia Jordan, superintendent.

Touro Infirmary, New Orleans, Dr. A. B. Tipping, superintendent.

#### MAINE

- The Eastern Maine General Hospital, Bangor, Miss Ida Washburn, R.N., superintendent.  
Presque Isle General Hospital, Presque Isle, Miss Margaret B. Cowan, R.N., superintendent.

#### MARYLAND

- The Church Home & Infirmary, Baltimore, Miss Jane S. Nash, superintendent.  
Franklin Square Hospital, Baltimore, Dr. F. S. Robertson, superintendent.  
Hebrew Hospital, Baltimore, Dr. H. J. Moss, superintendent.  
The Hospital for the Women of Maryland, Baltimore, Miss Stella W. Sampson, superintendent.  
Johns Hopkins Hospital, Baltimore, Mr. Winford H. Smith, superintendent.  
Maryland General Hospital, Baltimore, Mr. George Clarke Peck, superintendent.  
The Union Memorial Hospital, Baltimore, Miss Roberta L. Ball, R.N., superintendent.

#### MASSACHUSETTS

- Athol Memorial Hospital, Athol, Mrs. Sarah D. Kandall, superintendent.  
Boston Dispensary, Boston, Miss Caroline B. Wilks, superintendent.  
Peter Bent Brigham Hospital, Boston, Dr. Joseph B. Howland, superintendent.  
Bristol County Tuberculosis Hospital, Attleboro, Dr. Adam S. MacKnight, superintendent.  
Brockton Hospital, Brockton, Mr. Loring B. Packard, superintendent.  
Cambridge Hospital, Cambridge, Miss Josephine E. Thurlow, superintendent.  
Collis P. Huntington Memorial Hospital, Boston, Miss Anna L. Gibson, superintendent.  
The Faulkner Hospital, Boston, Miss Ruth Gardner Clark, superintendent.  
Franklin County Public Hospital, Greenfield, Miss Annie S. Barclay, superintendent.  
Henry Heywood Memorial Hospital, Gardner, Miss Marietta D. Barnaby, superintendent.  
The Anna Jaques Hospital, Newbury Port, Miss Violet L. Kirke, superintendent.  
The Malden Hospital, Malden, Miss Rachel McEven, superintendent.

The Memorial Hospital, Worcester, Miss Lucia L. Jaquith, R.N., superintendent.  
 The New England Baptist Hospital, Boston, Miss Emma A. Anderson, superintendent.  
 New England Deaconess Hospital, Boston, Miss Adeliza A. Betts, superintendent.  
 Springfield Hospital, Springfield, Mr. W. C. Lyon, superintendent.  
 St. Luke's Hospital, New Bedford, Miss Elizabeth W. Marsh, superintendent.  
 Union Hospital Fall River, Fall River, Miss Anna E. Rothrock, superintendent.  
 Vincent Memorial Hospital, Boston, Miss Jean C. Fraser, superintendent.  
 Wesson Maternity Hospital, Springfield, Miss Winifred H. Brooks, R.N., superintendent.  
 Winchester Hospital, Winchester, Miss Bessie L. Norton, superintendent.  
 Worcester Hahnemann Hospital, Worcester, Miss Suzanne M. Freeman, superintendent.

#### MICHIGAN

The Battle Creek Sanitarium, Battle Creek, Dr. J. H. Kellogg, superintendent.  
 Bronson Hospital, Kalamazoo, Mr. E. G. Wildermuth, superintendent.  
 Children's Free Hospital, Detroit, Miss Margaret A. Rogers, superintendent.  
 W. A. Foot Memorial Hospital, Jackson, Mr. Harry B. Neagle, superintendent.  
 The Grace Hospital, Detroit, Dr. W. L. Babcock, superintendent.  
 Hackley Hospital, Muskegon, Miss Grace D. McElderry, superintendent.  
 Harper Hospital, Detroit, Mr. Stewart Hamilton, superintendent.  
 Highland Park Contagious Hospital, Highland Park, Dr. W. N. Braley, superintendent.  
 Hurley Hospital, Flint, Miss Anna M. Schutt, superintendent.  
 Mercy Hospital, Grayling, Sister M. Ligouri Thibodean, superintendent.  
 Nichols Memorial Hospital, Battle Creek, Miss Helen L. Bloomfield, superintendent.  
 Receiving Hospital, Detroit, Dr. William Bailey, superintendent.

Saginaw General Hospital, Saginaw, Miss Lenna Matthews, superintendent.  
Saginaw Woman's Hospital, Saginaw, Miss Lydia Thompson, superintendent.  
University Hospital, Ann Arbor, Dr. C. G. Parnall, superintendent.  
Westerlin Hospital, Iron Mountain, Dr. William J. Anderson, superintendent.  
Woman's Hospital, Detroit, Miss Carrie L. Eggert, superintendent.

#### MINNESOTA

Asbury Hospital, Minneapolis, Mrs. Sarah H. Knight, superintendent.  
The City and County Hospital, St. Paul, Dr. Arthur B. Ancker, superintendent.  
The Mayo Clinic, Rochester.  
Norwegian Lutheran Deaconess Hospital, Minneapolis, Miss Lena Nilson, superintendent.  
St. Luke's Hospital Association, Duluth, Dr. A. J. McRae, superintendent.  
St. Mary's Hospital, Rochester, Sister Mary Joseph, superintendent.  
The Swedish Hospital, Minneapolis, Mr. G. W. Olson, superintendent.  
Western Minnesota Hospital, Graceville, Miss Anna M. Emge, R.N., superintendent.  
Winona General Hospital, Winona, Miss Catherine H. Allison, R.N., superintendent.

#### MISSOURI

Barnes Hospital, St. Louis, Dr. L. H. Burlingham, superintendent.  
Jewish Hospital of St. Louis, St. Louis, Miss Margaret Rogers, superintendent.  
Missouri Baptist Sanitarium, St. Louis, Dr. B. A. Wilkes, superintendent.  
Research Hospital, Kansas City, Mr. Fred L. Woddell, superintendent.  
Springfield Hospital, Springfield, Miss Vida R. Nevison, superintendent.  
St. Louis Maternity Hospital, St. Louis, Miss Annette B. Cowles, superintendent.  
Wheatley-Provident Hospital, Kansas City, Mr. J. Edward Perry, superintendent.

#### MONTANA

St. Ann's Hospital, Anaconda, Sister M. Carlotta, superintendent.

Murray Hospital, Butte, Mr. Donald Campbell, superintendent.

#### NEBRASKA

Fremont Hospital, Fremont, Miss Marie L. White, superintendent.

Nebraska Methodist Episcopal Hospital, Miss Blanche M. Fuller, superintendent.

The Swedish Mission Hospital, Omaha, Mr. Albin N. Osterholm, superintendent.

#### NEW HAMPSHIRE

Elliot Hospital, Manchester, Miss Helen Cauerly, superintendent.

The Mary Hitchcock Memorial Hospital, Hanover, Miss Ida Frances Shepard, superintendent.

Memorial Hospital, North Conway, Miss Ellen Riley, superintendent.

Nashua Memorial Hospital, Nashua, Miss Martha A. Wallace, superintendent.

#### NEW JERSEY

Dover General Hospital, Dover, Miss Elizabeth Miller, superintendent.

The Hackensack Hospital, Hackensack, Miss Mary J. Stone, superintendent.

Middlesex General Hospital, New Brunswick, Miss M. Louise Pugh, superintendent.

Monmouth Memorial Hospital, Long Branch, Mrs. Martha M. Scott, superintendent.

Nathan & Miriam Barnert Memorial Hospital, Paterson, Mr. David Schwab, superintendent.

Newark Beth Israel Hospital, Newark, Mr. Joseph Karkakis, superintendent.

Passaic General Hospital, Passaic, Miss Margaret A. Wallace, superintendent.

The Presbyterian Hospital, Newark, Miss Almey Constance Murray, R.N., superintendent.

The Somerset Hospital, Somerville, Miss J. B. Hamilton, superintendent.

#### NEW YORK

Bellevue Hospital, New York City, Dr. George D. O'Hanlon, in charge.

Beth Israel Hospital, New York City, Mr. Louis J. Frank, superintendent.



Binghamton City Hospital, Binghamton, Dr. Frederick W. Splint, superintendent.  
 Bradford Street Hospital, Brooklyn, Miss Margaret Lacey, chief nurse.  
 Broad Street Hospital, Oneida, Miss Jessie Broadhurst, superintendent.  
 The Brooklyn Hospital, Brooklyn, Dr. Willis G. Nealley, superintendent.  
 Central Neurological Hospital, Blackwell's Island, Mr. B. Cosgrove, superintendent.  
 City Hospital, Blackwell's Island, Dr. Charles B. Bacon, in charge.  
 Coney Island Hospital, Brooklyn, Miss Maude J. Kean, in charge.  
 Cumberland Street Hospital, Brooklyn, Dr. William F. Jacobs, in charge.  
 Flower Hospital, New York City, Lt. Col. Henry D. Thomason, superintendent.  
 Fordham Hospital, New York City, Miss Hannah Malmgren, in charge.  
 Frederick Ferris Thompson Hospital, Canandaigua, Miss Elsie K. Kraemer, R.N., superintendent.  
 General Hospital of Saranac Lake, Saranac Lake, Miss Emily Denton, superintendent.  
 Gouverneur Hospital, New York City, Miss Jessie A. Stowers, in charge.  
 Glens Falls Hospital, Glens Falls, Miss Florence M. V. Lutts, superintendent.  
 Greenpoint Hospital, Brooklyn, Dr. Raymond D. Laub, in charge.  
 Hahnemann Hospital, New York City, Dr. Wiley E. Woodbury, director.  
 Hahnemann Hospital of Rochester, Dr. T. K. Gruber, superintendent.  
 Harlem Hospital, New York City, Mr. Cosmo D. O'Neil, in charge.  
 Hospital for Joint Diseases, New York City, Mr. Charles F. Diehl, superintendent.  
 Hospital for Ruptured & Crippled, New York City, Mr. J. D. Flick, superintendent.  
 The Ithaca City Hospital, Ithaca, Miss Grace B. Beattie, R.N., superintendent.  
 O. E. Jones General Hospital, Jamestown, Miss Marie Robertson, superintendent.  
 Kings County Hospital, Brooklyn, Dr. Mortimer D. Jones, in charge.

Kingston Avenue Hospital, Brooklyn, Dr. W. T. Cannon,  
 in charge.  
 Knickerbocker Hospital, New York City, Miss Lucy M.  
 Moore, superintendent.  
 Lincoln Hospital & Home, New York City, Dr. Frederick  
 W. Gwyer, superintendent.  
 Nathan Littaner Hospital, Gloversville, Miss Josephine H.  
 Combs, superintendent.  
 Lutheran Hospital, Brooklyn, Miss Augusta E. Abel,  
 superintendent.  
 Manhattan Maternity & Dispensary, New York City, Miss  
 Nancy E. Cadmas, superintendent.  
 Mary Imogene Bassett Hospital, Cooperstown, Dr. Nelson  
 G. Gapen, superintendent.  
 Memorial Hospital for Treatment of Cancer & Allied  
 Diseases, New York City, Mr. George F. Holmes, super-  
 intendent.  
 Metropolitan Hospital, Blackwell's Island, Dr. Walter H.  
 Conley, in charge.  
 Metropolitan Life Insurance Co. Sanatorium, Mt. Mc-  
 Gregor, Dr. Horace J. Howk, physician in charge.  
 Montefiore Home & Hospital for Chronic Diseases, New  
 York City, Mr. M. D. Goodman, superintendent.  
 Mount Sinai Hospital, New York City, Dr. S. S. Gold-  
 water, director.  
 Municipal Sanitarium for Tuberculosis, Otisville, Dr. Don-  
 ald D. Campbell, in charge.  
 Neponsit Hospital, Neponsit, Miss Josephine T. Brass, in  
 charge.  
 New York City Children's Hospital, Randall's Island, Dr.  
 James F. Vavasour, in charge.  
 New York Nursery & Child's Hospital, New York City,  
 Mrs. F. Wilmarth Kinsey, superintendent.  
 Olean General Hospital, Olean, Mrs. Ethel Henders Bates,  
 superintendent.  
 Park Avenue Hospital, Rochester, Miss Mary Elizabeth  
 Morris, superintendent.  
 The Presbyterian Hospital in the City of New York, New  
 York City, Dr. C. H. Young, superintendent.  
 Queensboro Hospital, Jamaica, L. I., Dr. F. S. Westmore-  
 land, in charge.  
 Reconstruction Hospital, New York City, Mr. Walter T.  
 Pilgrim, superintendent.  
 Riverside Hospital, New York City, Dr. T. F. Joyce, in  
 charge.

Rochester General Hospital, Rochester, Miss Mary L. Keith, superintendent.  
 Rochester Homeopathic Hospital, Rochester, Miss Maude L. Johnston, superintendent.  
 St. Francis Hospital, Port Jervis, Sister M. Seraphine, superintendent.  
 St. Luke's Home & Hospital, Utica, Mr. I. W. J. McClain, superintendent.  
 Seas View Hospital, Staten Island, Dr. Geza Kremer, in charge.  
 The Society of the New York Hospital, New York City, Dr. Thomas Howell, superintendent.  
 Soldiers' and Sailors' Memorial Hospital, Penn Yan, Mrs. Ella M. Gibson, superintendent.  
 The Staten Island Hospital, Tompkinsville, Dr. Chas. W. Goodwin, superintendent.  
 Willard Parker Hospital, New York City, Dr. E. Giddings, in charge.  
 The Woman's Hospital in the State of New York, New York City, Dr. Elizabeth Johnson van Slyke, superintendent.

#### NORTH CAROLINA

Clarence Barker Memorial Hospital, Biltmore, Miss Mary P. Laxton, superintendent.  
 The Edgecombe General Hospital, Tarboro, Miss E. Mildred Davis, superintendent.  
 St. Agnes Hospital, Raleigh, Mrs. A. B. Hunter, superintendent.  
 Watts Hospital, West Durham, Dr. C. D. Hill, superintendent.

#### OHIO

Alliance City Hospital, Alliance, Miss Charlotte A. Frye, superintendent.  
 Ashtabula General Hospital, Ashtabula, Miss Clara B. Peck, superintendent.  
 Bethesda Hospital, Zanesville, Miss Lillian L. Allen, superintendent.  
 Brown Memorial Hospital, Conneaut, Miss Jessie J. Hubbard, superintendent.  
 Cherrington Hospital, Logan, Dr. Jacob Hyman, superintendent.  
 The Cincinnati Sanitarium, Cincinnati, Dr. Egbert W. Fell, superintendent.  
 The City Hospital of Akron, Akron, Miss Marie A. Lawrence, superintendent.

The City Hospital, Bellaire, Miss Jennie C. Quimby, superintendent.  
 The Cleveland Homeopathic Hospital, Cleveland, Miss Alma C. Dogle, superintendent.  
 Cleveland Hospital Council, Cleveland, Mr. Howell Wright, executive secretary.  
 The Deaconess Hospital, Cleveland, Mr. A. G. Lohman, superintendent.  
 The Episcopal Hospital for Children, Cincinnati, Miss Mary Jones, superintendent.  
 Findlay Home & Hospital, Findlay, Miss Mary L. Margerum, superintendent.  
 The Flower Deaconess Home and Hospital, Toledo, Miss Hazel M. Runyan, R.N., superintendent.  
 Good Samaritan Hospital, Cincinnati, Sister Rose Alexius, superintendent.  
 Good Samaritan Hospital, Sandusky, Miss Olga Busch, superintendent.  
 Good Samaritan Hospital, Zanesville, Mother M. Alexis, superintendent.  
 The Jewish Hospital, Cincinnati, Mr. M. M. Russell, superintendent.  
 Lakeside Hospital, Cleveland, Dr. R. H. Bishop, Jr., superintendent.  
 Lima Hospital Society, Lima, Miss Margaret B. Mateer, superintendent.  
 Mansfield General Hospital, Mansfield, Miss Elsie Drugan, superintendent.  
 Martins Ferry Hospital, Martins Ferry, Miss Caroline L. Butterfield, superintendent.  
 The Mary Day Nursery & Children's Hospital, Akron, Mr. Arthur O. Bauss, superintendent.  
 Massillon Hospital, Massillon, Miss Delna I. Hathaway, superintendent.  
 The Maternity Hospital, Cleveland, Miss Calvina MacDonald, superintendent.  
 Maternity & Children's Hospital, Toledo, Miss Addie L. Murphy, superintendent.  
 Memorial Hospital, Fremont, Miss Daisy C. Kingston, superintendent.  
 Mercy Hospital, Toledo, Mother M. Bernardine, president.  
 Mount Sinai Hospital of Cleveland, Cleveland, Mr. F. E. Chapman, superintendent.  
 The Painesville Hospital, Painesville, Miss Anna McLaughlin, superintendent.

St. Elizabeth's Hospital, Youngstown, Sister M. Genevieve, superintendent.  
 St. John's Hospital, Cleveland, Sister Amadeus, superintendent.  
 St. Luke's Hospital, Cleveland, Mr. C. B. Hildreth, superintendent.  
 St. Vincent Charity Hospital, Cleveland, Sister M. Brigid, superintendent.  
 The Toledo Hospital, Toledo, Mr. P. W. Behrens, superintendent.  
 Warren City Hospital, Warren, Miss Mary E. Surbray, superintendent.  
 Women's Hospital, Cleveland, Miss Frances H. Bescherer, superintendent.  
 Youngstown Hospital Association, Youngstown, Mr. R. W. Yengling, superintendent.

#### OKLAHOMA

Morningside Hospital, Tulsa, Miss D. F. Browne, superintendent.  
 Tulsa Hospital, Tulsa, Mrs. A. R. Bentley, superintendent.

#### OREGON

Good Samaritan Hospital, Portland, Miss Emily L. Lovelidge, superintendent.

#### PENNSYLVANIA

Beaver Valley General Hospital, New Brighton, Miss Elizabeth G. Gainor, superintendent.  
 Braddock General Hospital, Braddock, Miss Margaret W. Woodside, superintendent.  
 Chester Hospital, Chester, Dr. John A. Drew, superintendent.  
 Children's Homeopathic Hospital of Philadelphia, Miss Anna L. Schulze, superintendent.  
 The Children's Hospital of Philadelphia, Philadelphia, Miss Mary E. Boteler, R.N., superintendent.  
 Clearfield Hospital, Clearfield, Miss Josephine E. Oler, superintendent.  
 Conemaugh Valley Memorial Hospital, Johnstown, Miss Katharine A. Moyer, superintendent.  
 Corry Hospital, Corry, Miss Faith A. Collins, superintendent.  
 The Cottage State Hospital, Miss Fannie A. Dougherty, superintendent.  
 Easton Hospital, Easton, Miss Susan V. Sheaffer, superintendent,

Eye & Ear Hospital of Pittsburgh, Pittsburgh, Miss Evelyn, Anderson, superintendent.  
 Garretson Hospital of Temple University, Philadelphia, Miss Anna M. Lynch, superintendent.  
 Germantown Dispensary and Hospital, Germantown, Mr. Chas. A. Gill, superintendent.  
 Good Samaritan Hospital, Lebanon, Miss C. C. Lallman, superintendent.  
 Homeopathic Medical & Surgical Hospital, Reading, Miss Lucie K. Wright, superintendent.  
 Hospital of Woman's Medical College, Philadelphia, Dr. Ellen C. Potter, superintendent.  
 Jefferson Hospital, Philadelphia, Dr. Henry K. Mohler, medical director.  
 Kensington Hospital for Women, Philadelphia, Miss Florence C. Beck, superintendent.  
 Lancaster General Hospital, Lancaster, Mr. W. M. Breitinger, superintendent.  
 The Lankenau Hospital, Philadelphia, Dr. Henry F. Page, superintendent.  
 McKeesport Hospital, McKeesport, Mr. D. F. Owen, superintendent.  
 Mercy Hospital, Altoona, Miss Laura M. Hamer, superintendent.  
 The Mercy Hospital, Pittsburgh, Sister M. Etheldreda, superintendent.  
 Montgomery Hospital, Norristown, Miss Eliza Davies, superintendent.  
 Mount Sinai Hospital, Philadelphia, Dr. Albert S. Hyman, superintendent.  
 Oil City Hospital, Oil City, Miss Clara B. Peck, superintendent.  
 Robert Packer Hospital, Sayre, Mr. Howard E. Bishop, superintendent.  
 Pennsylvania Hospital, Philadelphia, Mr. Daniel D. Test, superintendent.  
 Pittsburgh Hospital Sisters of Charity, Pittsburgh, Sister Mary Francis, superintendent.  
 Pittston Hospital Association, Pittston, Miss Esther J. Tinsley, superintendent.  
 St. Francis Hospital, Pittsburgh, Sister M. Thomasine Diemer, superintendent.  
 St. Joseph's Hospital, Lancaster, Sister Mary Herman, superintendent.  
 St. Joseph's Hospital & Dispensary, Pittsburgh, Sister M. Bonaventure, superintendent.



St. Luke's Homeopathic Hospital, Philadelphia, Mr. Geo. W. Wayson, superintendent.  
St. Luke's Hospital, Bethlehem, Mr. Howard E. Neumer, superintendent.  
South Side Hospital of Pittsburgh, Pittsburgh, Miss Jean L. Jones, superintendent.  
Suburban General Hospital, Bellevue, Miss E. Driscoll, superintendent.  
Warren General Hospital, Warren, Miss Margaret McLaren, superintendent.  
West Philadelphia Hospital for Women, Philadelphia, Miss Elizabeth Watson, business manager.  
Wilkes Barre City Hospital, Wilkes Barre, Mr. Elmer E. Matthews, superintendent.  
Women's Southern Homeopathic Hospital, Philadelphia, Dr. Lydia Webster Stokes, superintendent.

#### RHODE ISLAND

The Memorial Hospital, Pawtucket, Miss Nelle M. Selby, superintendent.

#### SOUTH CAROLINA

Anderson County Hospital, Anderson, Miss Rosa Helen Nickles, superintendent.  
Greenville City Hospital, Greenville, Miss Ethel A. Johnson, superintendent.  
The Roper Hospital, Charleston, Mr. F. Oliver Bates, superintendent.  
Steady Clinic & Sanitarium, Chick Springs, Mrs. Frances M. Montgomery, superintendent.

#### SOUTH DAKOTA

Methodist Deaconess Hospital, Rapid City, Miss Elva L. Wade, superintendent.

#### TENNESSEE

Baird-Dulaney Hospital, Dyersburg, Dr. E. H. Baird, superintendent.  
Gartly-Ramsay Hospital, Memphis, Mr. R. G. Ramsay, superintendent.  
Newell and Newell Sanitarium, Chattanooga, Miss Maud Heaton, R.N., superintendent.  
West Ellis Hospital, Chattanooga, Miss Carolyn E. Ferrel, superintendent.

#### TEXAS

All Saints Hospital, Fort Worth, Miss Margery House, superintendent.

Baptist Sanitarium & Hospital, Houston, Mrs. J. P. Burnett, superintendent.  
Robt. B. Green Memorial Hospital, San Antonio, Dr. H. Philip Hill, superintendent.  
Herman Hospital, Houston, Mr. W. A. Childress, manager.  
Lubbock Sanitarium, Lubbock, Mr. A. R. Ponton, superintendent.  
The Physicians and Surgeons Hospital, Corsicana, Mr. S. H. Hornbeak, superintendent.  
Sherman Hospital, Sherman, Mr. E. J. Neathery, superintendent.  
Sanitarium of Paris, Paris, Miss Elizabeth M. Hilf, superintendent.  
Texas Baptist Memorial Sanitarium, Dallas, Mr. J. B. Franklin, superintendent.

#### UTAH

Holy Cross Hospital, Salt Lake City, Sister M. Beniti, superintendent.  
St. Mark's Hospital, Salt Lake City, Mrs. N. F. W. Crossland, superintendent.  
Tooele General Hospital, Dr. G. W. Goins, physician in charge, Tooele, Utah.

#### VERMONT

Rutland Hospital, Rutland, Miss Mary Carr Newell, R.N., superintendent.  
St. Albans Hospital, St. Albans, Miss Mary A. Burns, superintendent.

#### VIRGINIA

The Stuart Circle Hospital, Richmond, Miss Rose Z. Van Vort, R.N., superintendent.

#### WASHINGTON

Lakeside Hospital, Seattle, Miss Cora West, R.N., superintendent.  
St. Joseph's Hospital, Aberdeen, Sister M. Valentine, superior.

#### WEST VIRGINIA

Hoffman Hospital, Keyser, Mr. C. S. Hoffman, superintendent.  
Ohio Valley General Hospital Association, Wheeling, Dr. C. D. Wilkins, superintendent.  
Parkersburg City Hospital, Parkersburg, Miss Emma Vernon, superintendent.

#### WISCONSIN

- Columbia Hospital, Milwaukee, Dr. C. W. Munger, superintendent.  
Milwaukee Children's Hospital, Milwaukee, Miss Gertrude I. McKee, superintendent.  
The Milwaukee Infant's Hospital, Milwaukee, Miss Nan Dunneen, superintendent.  
Milwaukee Maternity & General Hospital, Milwaukee, Mrs. Clara B. Hipke, superintendent.  
Mount Sinai Hospital, Milwaukee, Miss Helen L. Nipperman, superintendent.  
Roosevelt General Hospital, Milwaukee, Dr. Frederick, N. Sauer, superintendent.  
St. Luke's Hospital, Racine, Dr. J. G. Meachem, superintendent.  
Theda Clark Memorial Hospital, Neehah, Miss Louisa M. Lippert, superintendent.

#### WYOMING

- The Wheatland Hospital, Wheatland, Mrs. Margaret G. Phifer, R.N., superintendent.

#### CANADA

- Edmonton Hospital Board, Edmonton, Dr. Jas. C. Fyshe, superintendent.  
The Hospital for Sick Children, Toronto, Miss Florence J. Potts, superintendent.  
Montreal General Hospital, Montreal, Dr. A. K. Haywood, superintendent.  
Toronto General Hospital, Toronto, Dr. Chester J. Decker, superintendent.  
Vancouver General Hospital, Vancouver, Dr. M. T. MacEachern, superintendent.  
Victoria Hospital, London, Mr. T. H. Heard, superintendent.  
Winnipeg General Hospital, Winnipeg, Dr. George F. Stephens, superintendent.

#### PERSONAL MEMBERS

(Active and Associate)

#### ALABAMA

- Golightly, Mrs. B. M., superintendent, Birmingham Infirmary, Birmingham.  
Inscar, Miss Ida S., superintendent, The Moody Hospital, Dothan.

MacLean, Miss Helen, superintendent, Fraternal Hospital & Training School for Nurses, Birmingham.  
Moody, Mr. Earle F., The Moody Hospital, Dothan.

#### ALASKA

Davis, Mrs. Nettie S., Jacobsgaard & Jorgenson, Andersonsky.

#### ARKANSAS

- \*Schultz, Miss Caroline V., superintendent, St. John's Hospital, Fort Smith.  
Tye, Miss Menia S., superintendent, Sparks Memorial Hospital, Fort Smith.

#### CALIFORNIA

Ainsworth, Dr. F. K., Southern Pacific R. R. Hospital, San Francisco.

Arps, Mr. E. G., Franklin Hospital, San Francisco.

Baxter, Dr. Donald E., 833 Manhattan Place, Los Angeles.

- \*Brodrick, Dr. R. G., Director of Hospitals, Alameda County Hospital, San Leandro.

Brown, Dr. Robert, 1055 Pine St., San Francisco.

Christianson, Miss Jeanette A., 917 Third St., Santa Monica.

- \*Colburn, Miss Edith, R.N., Burnett Sanitarium, Fresno.  
Curry, Miss Margaret J., Children's Hospital, San Francisco.

Dorr, Dr. William R., superintendent, St. Luke's Hospital, San Francisco.

Dukes, Dr. Charles Alfred, Samuel Merritt Hospital, Oakland.

Henninger, Miss Alice G., R.N., superintendent, Seaside Hospital, Long Beach.

Levison, Mr. J. B., trustee, Mount Zion Hospital, San Francisco.

Levy, Mr. Louis Cooper, superintendent, Mount Zion Hospital, San Francisco.

Moffitt, Mr. J. K., First National Bank, San Francisco.

Musgrave, Dr. W. E., Children's Hospital, San Francisco.

O'Connor, Mr. John, superintendent, St. Francis Hospital, San Francisco.

Olmsted, Dr. Theodore, superintendent, Samuel Merritt Hospital, Oakland.

Rapple, Dr. W. C., University of California Hospital, San Francisco.

Seymour, Miss Adalenene Maude, R.N., superintendent, Burnett Sanitarium, Fresno.

Shatto, Miss Katherine, U. S. P. H. Hospital, Arrowhead Springs.  
 Somers, Dr. Geo. B., superintendent, Lane Hospital, San Francisco.  
 Wallace, Miss Margaret M., 602 E. Washington St., Santa Ana.  
 Williamson, Miss Annie A., 1414 Hope St., Los Angeles.  
 \*Wollenberg, Mr. C. M., superintendent, City and County Relief Home, San Francisco.  
 Young, Dr. Beverly, Arvin, Kern Co.

#### COLORADO

\*Clark, Mr. Pliny O., superintendent, Presbyterian Hospital, Denver.  
 Corwin, Dr. R. W., superintendent, Minnequa Hospital, Pueblo.  
 Culbertson, Miss Blanche, R.N., superintendent of nurses, Longmont Hospital, Longmont.  
 \*Cushman, Mrs. Oca, superintendent, Children's Hospital, Denver.  
 \*Holden, Dr. G., superintendent, Agnes Memorial Hospital, Denver.  
 Lamborn, Mr. H., superintendent, Park Ave. Hospital, Denver.  
 Reed, Dr. W. W., University of Colorado Hospital, Boulder.  
 Simon, Dr. S., National Jewish Hospital for Consumptives, Denver.  
 Swezey, Dr. Samuel, medical director and superintendent, National Jewish Hospital for Consumptives, Denver.

#### CONNECTICUT

Bloxham, Miss Nellie L., superintendent, Day-Kimball Hospital, Putnam.  
 \*Bresnahan, Dr. John F., superintendent, Bridgeport Hospital, Bridgeport.  
 Cassell, Mr. Wilson R., 1285 Boulevard, New Haven.  
 Cheney, Mr. L. R., 40 Woodland St., Hartford.  
 Comfort, Dr. Chas. W., superintendent, New Haven Dispensary, New Haven.  
 Cummins, Miss M. L., Charter Oak Private Hospital, Hartford.  
 Des Jardin, Miss Claire A., Asst. Supt., New Britain General Hospital, New Britain.  
 Dowd, Miss Kathleen A., Supt. Nurses, W. W. Backus Hospital, Norwich.

- Farnam, Mr. Henry W., 43 Hillhouse Avenue, New Haven.
- Fay, Mr. John E., superintendent, New Britain General Hospital, New Britain.
- Finn., Mrs. George A., 18 Lexington Ave., Greenwich.
- \*Hersey, Dr. Harold W., superintendent, New Haven Hospital, New Haven.
- \*Hunter, Miss Jean Allison, superintendent, Grace Hospital, New Haven.
- Hutchins, Mr. F. L., superintendent, W. W. Backus Hospital, Norwich.
- Kochersperger, Mr. H. M., director, Grace Hospital Society, New Haven.
- Love, Miss May L., superintendent, Litchfield County Hospital, Winsted.
- McGarry, Miss Mary C., superintendent, Charter Oak Private Hospital, Hartford.
- \*MacIver, Dr. George A., New Haven Hospital, New Haven.
- Mallory, Mr. Charles A., president, Danbury Hospital, Danbury.
- Mills, Miss Maud E., 45 Franklin St., New London.
- Moore, Dr. D. C. Y., trustee, Manchester Memorial Hospital, South Manchester.
- Murphy, Dr. James E., Wildwood Sanatorium, Hartford.
- \*Palmer, Mr. Chas. S., 114 Whitney Ave., New Haven.
- \*Prindiville, Miss K. M., superintendent, Lawrence & Memorial Associated Hospital, New London.
- Roche, Miss Elizabeth F., Asst. Supt., Litchfield County Hospital, Winsted.
- \*Rogerson, Mr. John J., Asst. Supt., Hartford Hospital, Hartford.
- Sexton, Dr. Lewis A., superintendent, Hartford Hospital, Hartford.
- \*Smith, Dr. Edw. W., F.A.C.S., Surgeon in Chief, Meriden Hospital, Meriden.
- Valencia, Mother, superintendent, St. Francis Hospital, Hartford.
- Wilson, Miss Irene, Lawrence Hospital, New London.
- Wolcott, Miss Grace L., superintendent, Waterbury Hospital, Waterbury.
- Woodruff, Mr. Rolin S., trustee, Grace Hospital Association, New Haven.



#### DELAWARE

- Duncan, Miss Jennette F., 305 West Eighth St., Wilmington.
- Reilly, Miss Helen T., superintendent, Hope Farm Sanatorium, Marshallton.
- Shaw, Mr. Benj. F., trustee, Delaware Hospital, Wilmington.
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# CONSTITUTION AND BY-LAWS AMERICAN HOSPITAL ASSOCIATION

(AS ADOPTED AT THE ANNUAL CONVENTION, SEPT. 8-12TH, 1918, CINCINNATI, OHIO.)

## ARTICLE I

The name of this Association shall be "The American Hospital Association."

## ARTICLE II

The object of this Association shall be to promote the welfare of the people so far as it may be done by the institution, care and management of hospitals and dispensaries with efficiency and economy, to aid in procuring the cooperation of all organizations with aims and objects similar to those of this Association; and in general, to do all things which may best promote hospital efficiency.

## ARTICLE III

Section 1. The membership of this Association shall be—

### A. Institutional.

Any corporation or association organized for the promotion of public health or for the care or treatment of the sick or injured shall be entitled to membership subject to the following:

Applications for institutional membership shall be addressed to the Executive Secretary in writing, signed by a duly authorized representative of the corporation or association; they shall be referred to the Membership Committee and the applicant shall become a member upon receiving the approval of the majority of the Membership Committee and upon the payment of the initiation fees as follows: Hospitals with a capacity of less than 100 beds shall pay ten dollars; those from 100-250 beds, inclusive, shall pay twenty dollars; all over 250 beds shall pay thirty dollars; all other organizations eligible to membership shall pay ten dollars.

Constituent Institutional Members shall be entitled to appoint as their representatives in the Association any person or persons who are eligible to active or associate membership in the Association, and of the number so appointed no more than three, including the Superintendent, shall have all the privileges and authority of active personal members and shall be so designated, and others so appointed shall have the privileges of associate personal members. . . . .

### B. Personal.

Active personal members shall be those who at the time of their election are trustees or superintendents, or assistant superintendents, of hospitals, or members of the medical staffs of hospitals, however such officials may be designated. Any person once an active personal member may continue such membership so long as the rules of the Association are conformed with.

Associate personal members shall, at the time of their election, be heads of any executive, administrative, or educational department of a hospital, other than as designated in Section 1B, or contributors to, or members of, any association or board, the object of which is the foundation, maintenance or improvement of hospitals or the promotion of

organized charities for the improvement of health. Associate personal members may hold office, but shall not have the right to vote at meetings of the Association.

Applications for active or associate personal membership shall be in writing, addressed to the Executive Secretary, and shall be endorsed by one or more members of the Association. They shall be referred to the Committee on Membership; and the applicant shall become a member upon receiving the approval of a majority of said Committee, and upon payment of an initiation fee of five dollars for active and two dollars for associate membership, which shall cover the dues payable at the next convention of the Association after election.

Section 2. Upon attaining any of the offices designated in Section 1B an associate personal member may become an active personal member by completing the payment of the dues for active personal members as provided in the By-Laws.

Section 3. Honorary personal membership after approval of the Membership Committee may be suggested at any session of the Association by any member for any person who by reason of public or private service, or for any other reason, should be entitled to such recognition; and such person may be elected an honorary personal member by a majority vote of those present at any subsequent session of the Association.

Honorary personal members shall have all the privileges of active personal members, except voting at meetings of the Association. They shall be exempt from the payment of dues.

#### ARTICLE IV: OFFICERS

Section 1. The officers of the Association shall be a President, President-Elect, three Vice-Presidents, an Executive Secretary, a Treasurer, and a Board of Trustees as herein provided.

The Executive Secretary shall serve as Secretary of the Board of Trustees.

Section 2: The above officers, other than the Board of Trustees and the Executive Secretary, shall be elected at each convention. The Executive Secretary shall be appointed by the Board of Trustees. They shall assume their duties at the close of the convention and shall serve until the close of the convention next succeeding, or until their successors are regularly elected and installed. Provided, however, that the President-elect shall assume the office of President at the next convention succeeding the convention of his election and that after the year 1919 no President shall be elected as such.

#### ARTICLE V: TRUSTEES

There shall be a Board of nine Trustees, which shall have charge of the property and financial affairs of the Association, and shall hold title thereto under the name of "Trustees of the American Hospital Association." The President, President-elect and Treasurer shall constitute three of said Trustees and two Trustees shall be elected annually, at the convention, to serve for three years, excepting that in 1919 one of said Trustees shall be elected for one year, one for two years and two for three years. Trustees shall serve until their successors are elected.

The Board of Trustees shall, always subject to the vote of the Association, have general control and management of the business of the Association, and may appoint and fix the salaries of such officers

and agents as it may deem necessary and expedient and establish rules and rates for the use of such facilities as it may in its judgment provide.

#### ARTICLE VI: SECTIONS

In order to facilitate the work of the Association, sections may be formed and discontinued from time to time, as the Trustees may by vote determine. Such sections may be geographic, in order that recognized meetings of the Association may be held in various parts in places not easily accessible to all members, or may be departmental in their nature and devoted to any recognized branch of hospital work. Proceedings of any authorized section of the Association approved by the Board of Trustees may become a part of the proceedings of the Association, and any resolution adopted by a geographic section shall be recognized as a motion duly made and seconded by any general session of the Association, and vote of the general Association shall be taken thereon.

#### ARTICLE VII: ANNUAL DUES

In order to provide funds for the maintenance of the Association, both institutional and personal members shall pay annual dues as may be determined by the By-Laws.

#### ARTICLE VIII: VACANCIES

Any vacancies occurring between the regular annual meetings in the office of the President, President-elect, the various Vice-Presidents, Treasurer, Executive Secretary or Board of Trustees, shall be filled temporarily by vote of the Board of Trustees; any other vacancies shall be filled temporarily by appointment of the President; and the appointees shall hold office until their successors are elected by the Association.

#### ARTICLE IX: AMENDMENTS

The Constitution and By-Laws may be amended by vote of not less than two-thirds of the members present and voting at a recognized general session of the Association; provided, however, that proposed amendments shall be submitted in writing at a recognized general session, and shall not be acted upon at a session at which they are proposed, but may be at any subsequent session.

### BY-LAWS

#### ARTICLE I

Section 1. There shall be an annual meeting or convention of the Association held at a time and place fixed by vote of the Association, or, if not so determined, by the Board of Trustees. The President and the Executive Secretary shall arrange programs for the convention.

Section 2. Special meetings may be called by the President, or in his absence, by a Vice-President, upon the written petition of not fewer than ten (10) members. This petition shall recite the object of the meeting. The President, through the Secretary, shall give notice of not less than sixty (60) days before the proposed time of such special meeting to each member of the Association, which notice shall also recite the object of the meeting.

Section 3. A quorum of the Association shall consist of not fewer than thirty (30) voting delegates or active members.

Section 4. Meetings of sections shall be held in accordance with the rules established by the enrolled members of the section hereinafter provided; provided, however, that such meetings shall not interfere with any general session of the Association.

#### ARTICLE II: ELECTIONS

Section 1. All officers shall be elected by ballot, excepting where it is otherwise ordered.

Section 2. A majority of the votes cast shall constitute an election.

Section 3. Only the delegates of the constituent institutional members so authorized by Article III, Section I, and active personal members shall be entitled to vote.

#### ARTICLE III: DUTIES OF OFFICERS

Section 1. The President shall preside at all meetings of the Association, and of the Board of Trustees, of which he shall be the Chairman. He shall appoint all committees, unless, by vote of the Association, other provisions shall be made. He shall be, ex officio, a member of all standing and special committees. The President-elect shall keep in close touch with the Association work as a member of the Board of Trustees, and otherwise during the year he holds the position in preparation for his assumption of the office of President.

Section 2. The Vice-President shall, in the order of their rank, in the absence of the President, perform his duties.

Section 3. Subject to instructions from the Association or from the Board of Trustees, the Executive Secretary shall be the general executive officer of the Association with duties, responsibilities, and privileges such as generally accompany such executive positions. He shall keep the minutes of the meetings and the records of the Association in books provided for these purposes. Subject to the order of the Trustees, he may serve as secretary of standing committees, except the Committee on the Nomination of Officers, and perform such other duties as the Association and the Board of Trustees shall direct. Under the direction of the Trustees, the Executive Secretary shall report to the Association the proceedings of the Trustees and also make such report of his own services as may be advisable.

Section 4. The Treasurer shall receive all dues and other moneys of the Association and shall deposit and account for same, under the direction and control of the Board of Trustees. He shall give to said Board such bond as it shall determine for the faithful performance of his trust. Such bond shall be in the custody of the President. All disbursements and expenditures shall be made under the direction of the Board of Trustees and subject to its rules and requirements. The Treasurer shall keep proper books of account, and shall present a report of the finances of the Association at the annual meeting.

#### ARTICLE IV

Section 1. The President shall, immediately after his election, appoint a Committee on Local Arrangements to consist of the President and Executive Secretary ex officio and such additional persons as he may deem advisable and also the following standing committees of three members each: namely, a Committee on Constitution and Rules, a Committee on Nomination of Officers, a Legislative Committee, a Membership Committee, and a Committee on Time and Place of Next Meeting, composed of a trustee, the Executive Secretary and a member at large, and the President shall also appoint a standing committee on

Out-Patient Work to consist of three members appointed by the President. The terms of office at the first appointment shall be so adjusted that one member shall go out of office annually. This Committee shall undertake such study or activity as may advance progress of out-patient service and shall report to the Association.

Section 2. The Committee on Nomination shall nominate to the convention the names of the candidates for President, three Vice-Presidents, Treasurer and two or more Trustees as vacancies exist. The action of this Committee is at all times subject to the approval of the convention. In the year 1919 it shall nominate a President-elect in addition to a President and thereafter shall nominate a President-elect instead of a President.

Section 3. The members of the Membership Committee shall consider all applications for membership, determine the eligibility of the applicant and express their approval or disapproval thereof to the Executive Secretary.

Section 4. The Committee on Constitution and Rules shall consider and report on all proposed amendments in the Constitution and By-Laws and all Rules of Order.

Section 5. The President shall have the power to appoint such special Committees as may be deemed desirable.

Section 6. The Legislative Committee shall, so far as possible, inform itself concerning all legislative procedure affecting the Association or the interests which it represents. Subject to the approval of the Association or Board of Trustees, it shall actively support all desirable legislation and actively oppose all unwise legislation.

#### ARTICLE V: DUES

Section 1. Constituent institutional members shall pay annual dues as follows: Hospitals of less than 100 beds shall pay annually \$10, hospitals of 100-250 beds shall pay annually \$25, hospitals of more than 250 beds shall pay annually \$50. All other institutional members shall pay annually the sum of \$10. States, counties, and municipalities shall pay in accordance with the above schedule for each institution accepted to membership. The maximum amount in such case shall, however, not exceed \$100.

Section 2. Dues of active personal members shall be \$5 and of associate personal members \$2 for each calendar year. Life personal members are exempt from the payment of annual dues. Dues shall be payable on or before the first day of March of each year at the office of the Executive Secretary, provided, however, that the dues of members acting as the delegates of institutional members shall, upon request of such personal members to the Treasurer, be remitted for the period of delegation.

Section 3. If said dues are not paid on or before the closing of the annual convention for the current year, the Executive Secretary shall notify the members in arrears, enclosing a copy of this section; and if said dues are not paid on or before the succeeding first day of January, the delinquent member shall be suspended and thereafter shall not be entitled to receive notices, or copies of transactions, or to participate in the meetings until all arrears are paid in full.

Section 4. At any time within three years after the date when dues are first required to be paid, a member who has been suspended shall be reinstated upon the payment of the amount of dues at the time of suspension. Otherwise membership in the Association shall be terminated.



#### ARTICLE VI: PUBLICATION OF PROCEEDINGS

Section 1. The Executive Secretary shall furnish the minutes and proceedings of the regular meetings for publication as soon thereafter as practicable.

Section 2. The Executive Secretary shall furnish to each member, except as provided in Article V, Section 2, a copy of this publication.

Section 3. The Treasurer shall upon the certification of the Executive Secretary pay all bills for printing and publication of the proceedings of the regular conventions.

Section 4. No paper shall be published in the minutes or in any magazine or paper as a part of the transactions of this Association except with the approval of the Trustees. All papers read at any session of the Association or its sections shall become the property of the Association, and when so requested the Board of Trustees may cause the same to be copyrighted in the name of the Trustees; but unless prohibited by the Trustees, the authors of all papers read at sessions of the Association or its sections may cause the same to be published, and, if approved by the Trustees, they may be published as a part of the transactions of the Association. No paper or magazine shall be entitled to the exclusive publication of any paper read before the Association or its sections except by vote of the Trustees.

#### ARTICLE VII: SECTIONS

Whenever a section is established by the Association or Trustees as provided in the Constitution, the President shall appoint a chairman and secretary thereof; and thereupon any delegate or member of the Association may become a member of such section by enrollment therein. When ten (10) or more delegates or members have so enrolled, the chairman shall call a meeting of such delegates or members, and they may thereupon make proper rules and by-laws for the guidance of such section, subject to the approval of the Trustees; and such rules may provide for the method of holding meetings, election of officers, and other matters necessary or important for the proper conduct of the section. The chairman and secretary appointed by the President shall act until their successors are chosen by the members of the section in accordance with the by-laws established by such section.

#### ARTICLE VIII: GUESTS

Delegates and members of the Association may have the privilege of inviting guests to the meetings, under such rules and regulations as the Trustees may from time to time provide. Guests thus introduced shall be permitted to participate in discussions.

#### ARTICLE IX: DISCIPLINE

Section 1. All charges of violation and infraction of rules or unbecoming conduct shall be referred to a special investigating committee of five appointed by the President.

Section 2. Due notice of the charges shall be given to the alleged offender, in writing, by the Executive Secretary of the Association.

Section 3. The Association shall have the right and authority to reprimand, suspend and expel any delegate or member guilty of violation of any of the provisions of the constitution or by-laws of the Association.

tion, after a full and fair investigation shall have been made.

Section 4. A four-fifths vote shall be necessary to sustain the action of such committee.

#### ARTICLE X: AMENDMENTS

These by-laws may be amended as provided by Article IX of the Constitution.

Adopted September 12, 1919, at the Annual Convention of the American Hospital Association, Cincinnati, Ohio.

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TRANSACTIONS  
OF THE  
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ASSOCIATION

*Twenty-third Annual  
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September 12th to 16th, 1921

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Mr. Paul H. Fesler, Superintendent, State University Hospital, Oklahoma City, Okla.  
Mr. F. O. Bates, Superintendent, Roper Hospital, Charleston, S. C.

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Mr. F. E. Chapman, Superintendent, Mount Sinai Hospital, Cleveland, Ohio.  
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Mr. Daniel D. Test, Superintendent, Pennsylvania Hospital, Philadelphia, Pa.

COMMITTEE ON TRAINING FOR HOSPITAL SOCIAL WORK.

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Miss S. Lillian Clayton, Director of Nurses, Philadelphia General Hospital, Philadelphia, Pa.  
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Miss Mary C. Jarrett, Associate Director, Smith College Training School for Social Work, Northampton, Mass.  
Mr. John A. Lapp, Editor, "The Nation's Health," Director, Social Action Division, National Catholic Welfare Council, Chicago, Ill.

- Dr. Winford H. Smith, Superintendent, Johns Hopkins Hospital, Baltimore, Md.
- Mr. Porter R. Lee, Director, The New York School for Social Work, New York, N. Y.
- Dr. Roger Irving Lee, Chairman, Executive Committee, Massachusetts Anti-Tubercular League, Boston, Mass.
- Miss Kate McMahon, Director, Social Service Department, Boston Dispensary, Boston, Mass.
- Dr. Frankwood E. Williams, Associate Medical Director, The National Committee for Mental Hygiene, New York, N. Y.
- Dr. Louis B. Baldwin, Superintendent, University Hospital, Minneapolis, Minn.
- Dr. Lewis A. Sexton, Superintendent, Hartford Hospital, Hartford, Conn.
- Dr. George O'Hanlon, Ex-officio, New York, N. Y., President of the American Hospital Association.
- Dr. A. R. Warner, Ex-officio, Chicago, Ill., Executive Secretary of the American Hospital Association.
- Miss Antoinette Cannon, *Executive Secretary*, Room 901, 105 East 22nd Street, New York, N. Y.

## PREVIOUS CONVENTIONS

### I—CLEVELAND, OHIO, SEPTEMBER 12-13, 1899

<i>Chairman</i>	<i>Secretary</i>
JAMES S. KNOWLES	C. S. HOWELL
Lakeside Hosp., Cleveland, Ohio	Western Penna. Hosp., Pittsburgh, Pa.
<i>Vice-Chairman</i>	<i>Treasurer</i>
HARRY W. CLARK	A. W. SHAW
Supt., Univ. Hosp., Ann Arbor, Mich.	Harper Hosp., Detroit, Mich.

### II—PITTSBURGH, PA., AUGUST 21-23, 1900

<i>Secretary</i>	<i>Chairman</i>
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Pittsburgh, Pa.	Cleveland, Ohio
<i>Treasurer</i>	<i>Vice-Chairman</i>
A. W. SHAW	HARRY W. CLARK
Detroit, Mich.	Ann Arbor, Mich.

### III—NEW YORK CITY, SEPTEMBER 10-12, 1901

<i>Chairman</i>	<i>Secretary</i>
CHAS. S. HOWELL	JAS. S. KNOWLES
Pittsburgh, Pa.	Cleveland, O.
Lakeside Hosp., Cleveland, Ohio	<i>Treasurer</i>
<i>Vice-Chairman</i>	A. W. SHAW
F. E. BECKER, M.D.	Detroit, Mich.
Newark, N. J.	

### IV—PHILADELPHIA, PA., OCTOBER 14-16, 1902

<i>Chairman</i>	<i>Secretary</i>
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<i>Vice-Chairman</i>	<i>Treasurer</i>
CHAS. O'REILLY, M.D.	A. W. SHAW
Toronto General Hosp., Toronto, Can.	Detroit, Mich.

### V—CINCINNATI, OHIO, OCTOBER 20-22, 1903

<i>President</i>	<i>Secretary</i>
JOHN FEHRENBATCH	DANIEL D. TEST
Cincinnati, O.	Philadelphia, Pa.
<i>Vice-President</i>	<i>Treasurer</i>
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Toronto, Can.	Detroit, Mich.

### VI—ATLANTIC CITY, N. J., SEPTEMBER 21-23, 1904

<i>President</i>	<i>Secretary</i>
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<i>Vice-Presidents</i>	<i>Treasurer</i>
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Providence, R. I.	
3. GEO. W. SAWYER	
Chicago, Ill.	

## PREVIOUS CONVENTIONS—CONTINUED

### VII—BOSTON, MASS., SEPTEMBER 26-29, 1905

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3. JAS. R. CODDINGTON  
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New York City

#### *Treasurer*

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Gen. Hosp., Paterson, N. J.

### VIII—BUFFALO, N. Y., SEPTEMBER 18-21, 1906

#### *President*

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#### *Vice-Presidents*

1. RENWICK ROSS, M.D.  
Buffalo, N. Y.
2. REV. GEO. C. HUNTING  
Salt Lake City, Utah
3. MISS M. L. KEITH  
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#### *Secretary*

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Philadelphia, Pa.

#### *Treasurer*

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Gen. Hosp., Paterson, N. J.

### IX—CHICAGO, ILL., SEPTEMBER 17-20, 1907

#### *President*

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Buffalo General Hosp., Buffalo,  
N. Y.

#### *Vice-Presidents*

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2. W. W. KENNEY  
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3. MISS ALICE M. RUSHBROOKE  
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Philadelphia, Pa.

#### *Treasurer*

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### X—TORONTO, CANADA, SEPTEMBER 29-OCTOBER 2, 1908

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#### *Vice-Presidents*

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#### *Treasurer*

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Chicago, Ill.

### XI—WASHINGTON, D. C., SEPTEMBER 21-24, 1909

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Chicago, Ill.

## PREVIOUS CONVENTIONS—CONTINUED

### XII—ST. LOUIS, MO., SEPTEMBER 20-23, 1910

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#### *Treasurer*

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### XIII—NEW YORK CITY, SEPTEMBER 19-22, 1911

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### XIV—DETROIT, MICH., SEPTEMBER 24-27, 1912

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### XV—BOSTON, MASS., AUGUST 26-29, 1913

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#### *Treasurer*

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### XVI—ST. PAUL, MINN., AUGUST 25-28, 1914

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## PREVIOUS CONVENTIONS—CONTINUED

### XVII—SAN FRANCISCO, CALIF., JUNE 22-25, 1915

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### XVIII—PHILADELPHIA, PA., SEPTEMBER 26-30, 1916

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### XIX—CLEVELAND, OHIO, SEPTEMBER 10-15, 1917

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RICHARD P. BORDEN

Trustee, Union Hospital, Fall  
River, Mass.

### XX—ATLANTIC CITY, N. J., SEPTEMBER 24-28, 1918

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Baltimore, Md.

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Trustee, Union Hospital, Fall  
River, Mass.

MARY L. KEITH, R.N.

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Rochester, N. Y.



## PREVIOUS CONVENTIONS—CONTINUED

### XXI—CINCINNATI, OHIO, SEPTEMBER 8-12, 1919

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#### *Executive Secretary*

HOWELL WRIGHT  
308 Anisfield Building, Cleveland,  
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### XXII—MONTREAL, QUEBEC, OCTOBER 4-8, 1920

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#### *President-Elect*

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3. MISS MARGARET ROGERS  
Supt., Jewish Hospital, St.  
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cago, Ill.

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Ohio.

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Director Health Dept. Hosp., New  
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#### *Executive Secretary*

A. R. WARNER, M.D.  
Office of the Association, 22 E.  
Ontario St., Chicago, Ill.

### XXIII—WEST BADEN, IND., SEPTEMBER 12-16, 1921

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Minneapolis, Minn.

#### *President-Elect*

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## PREVIOUS CONVENTIONS—CONTINUED

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### *Executive Secretary*

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Office of the Association,  
22 East Ontario St.,  
Chicago, Ill.

MINUTES OF THE  
TWENTY-THIRD ANNUAL CONFERENCE

of the  
AMERICAN HOSPITAL ASSOCIATION  
West Baden, Ind., September 12-16, 1921

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OPENING AND GENERAL SESSION

SEPTEMBER 13, 1921—10:00 a.m.

President Baldwin in the chair:

PROGRAM

*Address of Welcome*—by Dr. George F. Keiper, Lafayette, Indiana, President of the Indiana Hospital Association.

*President's Address*—by Dr. Louis B. Baldwin, President of the Association, Superintendent of the University Hospital, Minneapolis, Minnesota.

*Report of the Trustees*—by Dr. A. R. Warner, Executive Secretary. Accepted and ordered placed on file.

*Report of the Membership Committee*—by Dr. C. W. Munger, chairman. Accepted and ordered placed on file.

*Report of the Service Bureau on Dispensaries and Community Relations*—by Michael M. Davis, Jr., chairman. Accepted and ordered placed on file.

*Report of the Service Bureau on Hospital Social Work*—by Miss Ida M. Cannon, chairman. Accepted and ordered placed on file.<sup>6</sup>

*Report of the Executive Secretary*—by Dr. A. R. Warner, Executive Secretary of the Association. Accepted and ordered placed on file.

"Salaries Hospital Superintendents are now Receiving," by Mr. Joseph J. Weber, Managing Editor of the "Modern Hospital."

GENERAL SESSION

SEPTEMBER 13, 1921—2:00 p.m.

President Baldwin in the chair:

PROGRAM

"The Development of Good Professional Work in the Hospital," by Dr. Chas. S. Woods, Superintendent, Methodist Episcopal Hospital, Indianapolis, Indiana.

"Food Preservation"—by Mr. W. P. Heath of Chicago, Illinois.

ROUND TABLE

SEPTEMBER 13, 1921—3:00 p.m.

Dr. M. T. MacEachern in the chair:

PROGRAM

"What Constitutes Good Service to the Patient"—by Dr. M. T. MacEachern, Superintendent, Vancouver General Hospital, Vancouver, B. C.

Round Table Discussion on above topic for full time.

## GENERAL SESSION

SEPTEMBER 13, 1921—8:00 p.m.

President Baldwin in the chair:

### PROGRAM

"Medical and Hospital Care of Beneficiaries of the United States Veterans' Bureau"—by Dr. Haven Emerson, Veterans' Bureau, Washington, D. C.

## DISPENSARY SECTION

SEPTEMBER 14, 1921—10:00 a.m.

Mr. John E. Ransom in the chair:

### PROGRAM

"Cooperation Among City Dispensaries"—by Mr. Michael M. Davis, Jr., Executive Secretary of the Association of Out-Patient Clinics, New York, N. Y.

"Dispensary Needs of a Small City"—by Mr. S. G. Davidson, Superintendent, Rockford Hospital, Rockford, Illinois.

## SECTION ON HOSPITAL CONSTRUCTION

SEPTEMBER 14, 1921—10:00 a.m.

Dr. George O'Hanlon in the chair:

### PROGRAM

Round Table Discussion for full time.

## GENERAL ROUND TABLE ON DEPARTMENTAL PROBLEMS

SEPTEMBER 14, 1921—2:00 p.m.

Mr. Asa S. Bacon in the chair:

### PROGRAM

Round Table Discussion for full time.

A *motion* was made and seconded and carried unanimously that this meeting go on record as counting "all new born babies as patients."

## SECTION ON ADMINISTRATION

SEPTEMBER 14, 1921—2:00 p.m.

Dr. A. C. Bachmeyer in the chair:

### PROGRAM

"How Hospital Records Can Contribute to Health Protection"—by Dr. Haven Emerson, Veterans' Bureau, Washington, D. C.

"Vital Statistics a Hospital Should Collect and Publish"—by Dr. Nathaniel W. Faxon, Assistant Resident Physician, Massachusetts General Hospital, Boston, Mass.

A *motion* was made, seconded and adopted that this Section recommend to the Association the appointment of a Committee to formulate a standard annual report.

The Report of the Committee on Hospital Forms and Records was presented by Dr. A. C. Bachmeyer, Superintendent, Cincinnati General Hospital, Cincinnati, Ohio.

## SECTION ON SOCIAL SERVICE

SEPTEMBER 14, 1921—8:00 p.m.

Miss Ruth C. Emerson in the chair:

### PROGRAM

The report (in part) of the Special Committee making a survey of Hospital Social Service was read by Miss Ruth C. Emerson.

"Hospital Social Service as it Relates to the Administration of Dispensaries"—by Miss Janet Thornton, Member of the Staff, Committee on Dispensary Development, New York City, was read by Miss M. Antoinette Cannon.

## ROUND TABLE ON HOSPITAL ADMINISTRATION

SEPTEMBER 14, 1921—8:00 p.m.

Dr. A. C. Bachmeyer in the chair:

### PROGRAM

General Discussion of the Report on Hospital Forms and Records.

A *motion* made by Dr. Robert J. Wilson that the Report of the Committee on Hospital Forms and Records be accepted and the recommendations made about Committee being continued and the question of future work, be adopted. Motion was seconded to be adopted at a later General Session.

Dr. Christopher G. Parnall was elected as chairman and Dr. Nathaniel W. Faxon as secretary of the Committee for the ensuing year.

## ROUND TABLE ON DISPENSARY PROBLEMS

SEPTEMBER 14, 1921—9:00 p.m.

Mr. John E. Ransom in the chair:

### PROGRAM

General Discussion of Dispensary Problems.

## SECTION ON NURSING

SEPTEMBER 15, 1921—2:00 p. m.

Miss Mary M. Riddle in the chair:

### PROGRAM

"Shortage of Nurses in Our Schools, Causes and Remedies"—by Miss Nancy E. Cadmus, recent Superintendent of the Manhattan Maternity Hospital, New York, N. Y., read by Miss Mary E. Surbray of Peoria, Illinois.

"The Eight-hour Day for Student Nurses, Its Advantages and Disadvantages, and Some of the Arrangements Required for Establishment"—by Miss Hellena McMillan, Superintendent of the School for Nursing, Presbyterian Hospital, Chicago, Illinois, read by Miss Susan C. Francis.

"The Necessity for an Adequate and Reliable Curriculum in the Training School for Nurses"—by Miss Helen Wood, Superintendent of Nurses, Barnes Hospital, St. Louis, Missouri, read by Miss Jessie E. Catton.

"A Plea for Records in Training Schools"—by Miss G. Locke, Superintendent of Nurses, Memorial Hospital, Worcester, Mass., read by Miss Marie Louis.

Miss Laura R. Logan, Superintendent of Nurses, Cincinnati General Hospital, Cincinnati, Ohio, was elected chairman and Miss Clara B. Pound, Superintendent, Reid Memorial Hospital, Richmond, Indiana, was elected secretary of this Section.

JOINT GENERAL SESSION  
AMERICAN CONFERENCE ON HOSPITAL SERVICE  
AMERICAN HOSPITAL ASSOCIATION

SEPTEMBER 15, 1921—10:00 a.m.

Dr. Frank Billings in the chair:

PROGRAM

"The Work of the College in Standardization of Hospitals"—by Dr. Franklin H. Martin, Director General, American College of Surgeons, Chicago, Illinois.

"A Method of Increasing Medical Efficiency Within the Hospital"—by Dr. F. R. Nuzum, Medical Director, Santa Barbara College Hospital, Santa Barbara, California.

GENERAL SESSION

SEPTEMBER 15, 1921—8:00 p.m.

President Baldwin in the chair:

PROGRAM

The report of the Committee studying Flooring Materials for Hospitals was presented by Frank E. Chapman, chairman.

The report of the Special Committee on the subject of the Relation Between Hospitals and the State and City was presented by John E. Ransom, chairman.

A *motion* made and seconded at Administration Section to accept the Report of the Committee on Hospital Forms and Records was unanimously adopted.

A *motion* was adopted that the Committee on Hospital Records and Forms enlist the cooperation of some organized hospital group or groups in the reporting, at stated times, of hospital morbidity statistics.

The *motion* proposed by the Administration Section that the matter of considering, compiling and recommending standard forms and tables for hospital statistics and annual reports be referred to some existing Committee and to a specially appointed Committee by the Association was adopted.

The report of the Special Committee for the Study of State Subsidy for Hospitals was presented by Mr. Howell Wright, chairman.

A *motion* made by Mr. Pliny O. Clark that the report as submitted by Mr. Wright be accepted as a partial report, a report of progress and that the Committee be continued for another year was unanimously adopted.

The Committee on Constitution and Rules reported.

GENERAL SESSION  
CONDUCTED BY THE SECTION ON DIETETICS

SEPTEMBER 16, 1921—10:00 a.m.

Miss Lulu Graves in the chair:

PROGRAM

"The Dietitian an Asset to the Hospital"—by Miss Rena S. Eckman, Chief Dietitian, University Hospital, Ann Arbor, Michigan.



## GENERAL SESSION

SEPTEMBER 16, 1921—11:00 a.m.

President Baldwin in the chair:

### PROGRAM

"Cooperative Purchasing by Hospitals"—by Mr. Guy J. Clark, Purchasing Agent of the Cleveland Hospital Council, Cleveland, Ohio.

The report of the Committee on Constitution and Rules was adopted.

The Resolution Committee reported and resolutions were adopted.

## GENERAL SESSION

SEPTEMBER 16, 1921—2:00 p.m.

President Baldwin in the chair:

### PROGRAM

The report of the Treasurer and the Auditing Committee was presented by Mr. Asa S. Bacon and accepted and placed on file.

The report of the Committee on Nominations was read by the chairman.

A motion was adopted instructing the Secretary to cast one ballot for the nominees as presented.

President O'Hanlon takes the chair:

The Twenty-third Annual Conference of the American Hospital Association then adjourned.



## AMERICAN HOSPITAL ASSOCIATION

### TWENTY-THIRD ANNUAL CONFERENCE

West Baden, Indiana, September 13, 10 A. M.

#### Opening and General Session

President Baldwin in the Chair

THE CHAIR: The Twenty-third Annual Conference of the American Hospital Association will please come to order, and I am pleased to introduce Dr. George F. Keiper, of Lafayette, Ind., president of the Indiana Hospital Association, who will deliver the address of welcome in the absence of Governor McCray.

DR. GEORGE F. KEIPER: It is a matter of very great regret to us in Indiana that Governor McCray could not be with us. We have worked might and main in order to get him here, and your humble servant will be a very poor representative to take his place. We are very glad, of course, to have you here with us in this great and glorious state of Indiana. We are very proud of our state; we naturally would be as Hoosiers. There was a time, you know, when the term Hoosier was somewhat of an opprobrium as we went over the country and met the folks of those states that were more enlightened, apparently, than us, but those times have passed and I am reminded somewhat of the little boy who, a number of years ago, pioneered to the state of Indiana with his parents. After they had assembled all the stuff in their wagons—for they had to come by wagons in those days—they gathered all the folks together and, taking an inventory of all, they found that the small boy of the family was missing, and so they looked him up and they found him behind the barn crying for all he was worth. This story was told in a party of men gathered from Indiana and Ohio and this story was told by the Ohio man, and he said this little boy in the midst of his tears was saying, "Good-bye, God; I'm going to Indiana." The Indiana man spoke up and said, "That's all right, that's what the boy said, but that's not the way he said it. It is true he was shedding tears, but those were tears of joy, and this is really what he said, with all due deference to the name of Diety: "Good! By God, I'm going to Indiana!" So we hope this is the spirit in which you have all come to

Indiana at this time. Our new State Association is in a somewhat feeble condition, naturally, as it would be because we are so young. We were just born in April, but we are glad, as a State Association, to welcome you here. We believe that we have taken some advanced grounds so far as our Association ideas are concerned, and it seems to meet with the approval of these hospital authorities that govern this great organization. In the first place, we organized as a constituent branch of the American Hospital Association, in order that we might maintain the same relationship to the National Association as does our State Medical Association to the American Medical Association. Then, thinking the matter over, we found that there were in the neighborhood of sixty thousand doctors in this country connected with hospitals in an official capacity; that is, as members of the staffs, and we concluded that inasmuch as these sixty thousand doctors had such a vital interest in hospital management and development, we would take advanced ground in the state of Indiana and make the members of our staffs, as far as possible, members of our State Association, and that seems to be something newly started so far as state associations are concerned. We also believe thoroughly in organization in Indiana, and that led to the establishment of this Association, and as you are gathered here from all sections of the country, let me urge you who have not already organized state associations to do so and to gain the advantage that comes from organization. Witness the vast benefit that has come to the medical profession in the great organization of the American Medical Association; and I am sure that so far as the benefit is concerned, you can duplicate it and get the same amount of benefit by being organized in every state so far as state associations are concerned, and become constituents of this great Association. So, in conclusion, I wish to say to you that we bid you welcome to this great state and trust that your stay among us will not only be exceedingly pleasant but just as profitable.

President Baldwin then read his address, as follows:

**PRESIDENT BALDWIN:** Officers of the Association, in the past, have outlined what may be called the successive ages through which the American Hospital Association has passed. These ages or periods of development have been sympathetic to the needs of the time in the growth of the hospitals of the country which the Association has aimed to promote. They have been suggested as:

First, the period of the development of the hospital superintendent, of the man or woman who had to man and to make the institution he or she served.

Second, the period of hospital organization promoted by the establishment of the Association's headquarters and by the creation of bureaus and committees and state sections to study and apply standards of hospital function.

Third, the period of today upon which the American Hospital Association is consciously entering—the period of hospital service in the interest of the community the hospital serves.

It is my purpose to suggest some of the activities by which the service of the hospital to the community may be effectively and efficiently realized.

We have arrived at a time when the value of a public institution is to be measured in terms of social service rendered. It follows that the value of an association of institutions is to be measured by the success with which it promotes such service.

It is pertinent, therefore, to ask what functions the community expects or should expect the hospital to perform, or to the performance of which it should contribute. Valuable information and suggestions on this subject have already been contributed by such men as Dr. Haven Emerson and Dr. Winford H. Smith, and could not be better expressed than in the terms they have employed. In logical order so far as hospital service goes they are stated as:

1. The diagnosis and treatment of the sick.
2. The teaching of medicine.
3. The prevention of disease.

There has never been a time when the part that the hospital should play in the diagnosis and treatment of the sick has had the public recognition and created the public demand that it does today. It will be an increasingly large part in the future.

There has never been a time when it was so necessary that the hospital should so fitly fulfill its teaching function, when it should so freely serve as the medium through which the medical light of today may be handed down to the medical generations that are to follow.

There has never been a time when the social consciousness of our people has been so awake to the interests of public health and to those principles of disease prevention which the hospital should promote.

How may the American Hospital Association answer to the communal need of the country in the way of hospital service? The leadership of such an organization as this may do much by way of social direction.

An initial step is to secure a suitable classification of hospitals and to educate the public in the recognition of the nature and qualities of the institutions so classified. This classification should be dictated by the consideration of the sort of service the hospital renders, rather than by the means or method of its support. At once the private hospital, whether created by endowment or by gift, whether sustained by denominational bodies or by groups of physicians, falls into one large group. The major part of, and often the exclusive service that it renders, is to the patient who can pay. It may do beneficent service, as every hospital should, but it is not in any true sense entirely a charitable institution. Because, occasionally, it supports or secures endowment of a few free beds, it is not entitled to that term. It were better, perhaps, if it did not have any. It is essentially a hotel for the sick, in which rooms of varying quality and cost, board, nursing and domestic service are provided at a varying charge. It is a business enterprise. The public should expect it to be at all times solvent and self-supporting. Its deficits should be relieved by better business administration, by better budget control. It renders a social service to the sufficiently well to do and at a paying price.

Large numbers of the people who are sick cannot patronize the hotel for the sick. They are indigent at all times, by fault of persistent failure in health or inability of self-support. Or, as frequently, they are temporarily dependent upon social help because of illness; economically efficient under favorable circumstances, they are easily crowded to the financial wall by the added expense of sickness or the consequent inability to work for wages. They are subjects, not of charity, but of that measure of social justice which seeks to level the scales of inequality and misfortune. They call for the sort of service for which the second great group of public or general hospitals, under state, county, municipal or village control exists. They are supported, and should be amply supported by taxation. In capacity, from the general hospital, in the several departments of which all forms of disease are cared for, to the small community hospital, often not more than a house, which every vil-



lage may and should support, in which one or more rooms or small wards are well equipped for the care of the occasionally sick of the village, they vary widely. They should have adequate space not only for sick indigents but for those who may desire and be able to preserve their sense of self-dependency by the payment of a per diem charge—to be regarded as a special tax for hospital support.

Into a third group falls the teaching hospital attached to university medical school or college; supported by the state or by the teaching institution itself. It is as well to recognize this university relationship of the teaching hospital because the medical schools are rapidly passing under university control and because those that have not so seldom may boast of a teaching hospital.

The hospitals of this group exist for educational purposes. Their patients are selected and their retention governed by the purposes. By the fact of their teaching, in which all hospitals should share, but for which other hospitals do not specifically exist, they must make the superlatively good care and treatment of the sick their prime consideration. They must necessarily cultivate the diagnostic feature of their work and should support diagnostic clinic for the benefit of the sick through the medical profession at large. Custom dictates the social status of their inmates who may be termed pay, per diem or free patients. Two principles only need govern this question. Pay patients should be referred by physicians. The fees they pay should go to the institution and not to the staff.

The hospitalization of every community, large or small, should be made a matter of social survey and hospitals of each class should answer directly to social needs, so far as it exists. The public hospital is always a necessity, be it big or little. Under favorable circumstances temporary arrangements for the care of the indigent or economically disabled sick may be made by the town or village with a pre-existing private hospital, but in that event it should be under public supervision, its free or per diem wards should be supported by taxation and a special section of its budget should cover their operation. Too much emphasis cannot be put upon the necessity for the provision of more hospital accommodations, at moderate cost, for those of greatest number in every community, who are of slender means. The temporary help, under some form of per diem payment for hospital service

of those whom sickness puts upon the financially sick list, comes only second in importance.

Every such public hospital and even selected private hospitals, should be in close affiliation with the public health service of the community for the hospitalization of venereal and other communicable diseases. It is to the reproach of communities and our existing hospitals that but rarely may an institution be found which willingly admits infected persons of this class, whether poor or able to pay for service. While such patients should be under the medical or surgical care of the hospital staff, their quarantine or isolation should be under the control of the public health officer. From the hospital many of these venereal cases, so commonly associated with mental incompetency, should be dismissed, under similar control to a retention home.

One of the principal obstacles to the best community service of the public hospital must be recognized in the invasion of political influence into its governing mechanism of whatsoever type. It is a truism that this evil if not incurable is at least difficult of cure, save by the purification of our political systems as a whole—at present but a millennial prospect. Undoubtedly there is a choice of the method of control in the achievement of the most direct responsibility, whether of governing board, hospital administrator or general health officer in charge. Preference may be urged for the appointment, by the highest officer of the local government of a single official to whom the public health and hospital interests of the community should be entrusted without responsibility to any but the appointive head and without liability to removal save for established cause.

The authority of the administrator, director or superintendent of the hospital, of whatsoever type, should be adequate to the effective administration of the institution under his care. Conflict of authority between his office and that of the chief of staff or superintendent of nursing should be carefully safeguarded. Staff functions should be defined and scrupulously respected. In all matters of controversy the superintendent should be the final referee. If there must be a governing board over a public or a teaching hospital or a board of trustees over a private hospital it may wisely be of small membership. The inefficiency of the board of numerous managers is notorious and a common cause of at least partial paralysis of the executive. A governing board should delegate to

its executive a free hand and should reserve to itself only the power of review over the general policy of the institution, the initial approval of the budget and of the award of contracts recommended by him.

It is to be confessed that efficiency is not always the property of the hospital executive. The earlier efforts of the Association toward development of a higher type of executive should be perpetuated to the point of providing the means of actual training for this service, of attracting a high type of men and women to it and of the ultimate development of superior and better paid administrative quality.

The time has come—its coming has been recognized in some of our institutions—when the function of the hospital in the training of nurses should be transferred to educational institutions of university or college type, with which the hospital should affiliate for the purpose of giving to nursing students their laboratory or clinical opportunities. The university schools of nursing are multiplying. The Cleveland Survey commends them. They are setting new and needed standards. They are promoting a more attractive registration. The University of Minnesota has recently effected an arrangement between three other hospitals and its own teaching hospital for the maintenance of a single school of nursing, using the clinical service of the entire group for training, and assigning student nurses in succession to each. Such an association makes for a more complete and varied training of the nurse, for the standardization of nursing education and the development of a university spirit in its students.

Much remains to be done—without which real community hospital service cannot be achieved—in the cultivation in hospitals of every type, of an efficient business system, and to this vital need the American Hospital Association should address itself. That the usefulness of too many of our institutions is limited by the dry-rot of business inefficiency is very evident. The want of a budget, loose methods of purchasing, inadequate cost-accounting or none, the consequent lack of any basis for the proper scaling of the cost of service rendered and of charges to be paid for such service—these are faults which go far toward an explanation of the poverty, the annual deficit, the imperfect equipment of hospitals otherwise capable of good service.

In view of the foregoing observations I would suggest:

First: That the Association take early measures toward the creation of a bureau on community hospitalization, organization and administration; that it provide experts for the study of social needs and the information and assistance of community officials in these matters, whose services shall be given at reasonable charges going toward the maintenance of the bureau, which should be directed by a competent full-time chief.

The constructive work possible of accomplishment by such a bureau is incalculable in its range and results.

It might be possible, but doubtfully wise, to add this work to the function of other existing bureaus. Its specific quality suggests a distinctive organization.

Second: That the Association recognize the possibilities of progress to be realized in its most active participation in, and cooperation with the American Conference on Hospital Service. The interrelations of a body concerned with the attainment of the highest order of hospital service, with such organizations as compose the Conference are, or should be, very close.

Third: Because of the relatively small number of institutional memberships at the present time the membership of the Association imperfectly represents the hospitals of the country. The merit of a fee graduated to the size of the hospital is questionable. Would not an institutional membership fee alone of \$10.00 secure the initiation of most of the many hospitals not now represented and at the same time yield a revenue adequate to the Association's needs and to the important public service it has to render? The addition of every single hospital adds to the potential energy of the Association which it is our aim to fully actualize.

THE CHAIR: We will now listen to the report of the Board of Trustees, to be presented by Dr. Warner.

SECRETARY WARNER: The formal phraseology of the resolutions of the trustees is forbidding, but it is hoped that the Association will receive and adopt this report, which commits the Associations to the acts of the trustees and expresses your approval thereof, and makes, in so far as can be, those acts binding upon you. May I ask, therefore, that you, during the reading of this report, formulate your opinions and be prepared to express your judgment thereon?

## REPORT OF BOARD OF TRUSTEES

The trustees have held four meetings since the last report. The first and second were in Montreal, October 4 and October 8, and all trustees were present at each of these meetings. The third and fourth meetings were called in the office of the Association in Chicago, January 10 and June 20. At the first meeting on January 10 seven trustees were present and at the meeting on June 20, six trustees were present.

At each of these meetings the financial and other reports covering the conduct and routine work of the Association were presented and considered. In addition there were the following special actions:

At the first Montreal meeting various reports to be read before the Association were presented and considered.

The application of the Wisconsin Hospital Association to become a geographical section was presented in proper form and it was voted to approve the application and to extend recognition to this association as a geographical section.

At the second Montreal meeting called on October 8, the new president, Dr. L. B. Baldwin, presided. At this meeting, the Service Bureau on Hospital Work was authorized, and funds appropriated for its maintenance. The employment of Miss Ida M. Cannon as the director of this Bureau was also authorized.

The report of the director of the Service Bureau on Dispensaries and Community Relations then came up for official action. General approval of the work of this Service Bureau was expressed and the necessary appropriations for continuing it for the next year duly passed. This Service Bureau was by vote authorized to make local community surveys to determine the community needs for hospital service as well as surveys made to investigate the community relations of any particular hospital. Other policies and routine procedures for the conduct of the Service Bureaus were determined.

At the meeting held in Chicago, January 10, the first business was the consideration of the time and place for the holding of the 1921 Annual Conference. After considering the advantages and disadvantages of several places it was decided to hold this Conference in the West Baden Springs Hotel, West Baden, Ind.

After hearing a representative from the office of the Surgeon General, United States Public Health Service, on the question of opening a greater number of civil



hospitals to cases of pulmonary tuberculosis, the following resolution was adopted:

Whereas, In the past, not all general hospitals have accepted tuberculosis, and

Whereas, It has been demonstrated in a number of such institutions that this class of case may be admitted into separate wards without detriment to other patients, and

Whereas, Both for humanitarian reasons and for purposes of instruction, there is need for a change of policy in this regard, then be it

Resolved, That the trustees of the American Hospital Association recommend to the American Hospital Association that it pass a resolution to the effect that it recommend to the hospitals that separate wards be established in general hospitals, where possible, for the care of such patients.

The resolutions of the Michigan Hospital Association requesting recognition by the American Hospital Association as a section of said Association in and for the state of Michigan was presented. By vote the trustees granted this recognition and established the status of the Michigan Hospital Association as the Michigan Section of the American Hospital Association.

The trustees considered at length the petition requesting recognition of the Protestant Hospital Association as a section of the American. As the constitution of the latter provides only for departmental and geographical sections, this application could not be acted upon favorably. The resolution of the trustees was as follows:

Voted, That as the constitution of the American Hospital Association has no provision for the creating of a section as requested by the Protestant Hospital Association, the request be refused with the understanding that any propositions for cooperation with said Association will be given consideration if received.

By vote the trustees expressed final approval of the report made by the Committee on Hospital Social Service and authorized its circulation as a pamphlet of the Association, and bearing the approval of the trustees.

The trustees expressed their opinion that study of the education and training of the hospital social worker was at this time to be desired, and authorized the executive secretary to attend any meetings called for this purpose, to act for the Association, and to accept in the name of the Association the responsibility for carrying out such a study; provided that this acceptance shall not imply a



special appropriation from the funds of the Association, that the final appointment of the committee shall be made by the president of the Association, and that no report or plan of action shall be published as the result of the work of such a committee unless and until the same has been approved by the trustees.

By vote the trustees approved the proposed plans for the study of hospital floorings as presented by the executive secretary, and authorized the acceptance in the name of the Association of a gift of \$1,000.00 to establish a fund to be used exclusively for this purpose.

Mr. F. E. Chapman, superintendent, Mount Sinai Hospital, Cleveland, Ohio, was duly elected the chairman of a committee to carry on this work.

The trustees authorized and instructed the executive secretary to edit the extemporaneous discussions at the 1920 Conference, and publish the same without submitting them to the members.

Two new departmental sections were authorized—one on hospital dietetics and one on state or psychopathic hospital work, the section on dietetics to present a program at the Annual Conference. The time did not seem right for the development of a program on psychopathic work.

By vote the trustees expressed the desire to receive application from the hospital associations of the Provinces of Canada for recognition as geographical sections of the American Hospital Association.

The great value of routine autopsies to advance the professional work in hospitals, and the fact that at present the percentage of autopsies performed in many hospitals is far too low was discussed. The following resolution was unanimously adopted:

Whereas, It is universally agreed that a determination of the cause of death by autopsy contributes greatly to the advancement of vital statistics, and, in a large number of cases, is extremely advantageous to the family of the patient for the protection of social rights and for hygienic purposes and that the practice of routinely securing autopsies invariably results in bettering the medical work of the hospital, and

Whereas, The percentage of autopsies secured in many hospitals is so far below others that it can be explained only by indifference or neglect, be it

Resolved, That the trustees of the American Hospital Association do urge upon the Association, as a body, upon each member individually, and upon hospitals in general,

the necessity for diligent action on the part of physicians and surgeons practicing in hospitals to make every effort to secure the performance of autopsies in all cases of death in the hospital, and that hospital executives be held responsible for securing the performance of an adequate number of autopsies in their institutions, in order to insure the maximum benefit in the medical work of the institution.

At the meeting held in Chicago, June 20, the first special business transacted was the approval of an offer from an interested individual to provide funds to carry out a study of the clinical and administrative records and record keeping in hospitals. This fund was generous enough to provide for a full-time secretary of the committee so that the work could be rapidly pushed. This committee is reporting to this convention.

After a discussion of the far-reaching importance of the admission of venereal disease patients into hospitals, as well as the practical difficulties incident to these admissions, the following resolution was passed:

Whereas, It is now generally agreed that only a small percentage of venereal disease patients need bed treatment at any stage of their disease, and

Whereas, It is now established that bed treatment for the few who do need it is of short duration and benefits not only the patient but distinctly lessens a public health menace, and

Whereas, Knowledge of venereal disease is now so general that the psychology of all attendants can be depended upon to prevent contagion from all known cases of venereal disease, be it therefore

Resolved, That we, the trustees of the American Hospital Association, do hereby urge all hospital authorities to give consideration to this matter—to the end that all general hospitals shall admit venereal disease patients as other patients and enter these diagnoses as other diagnoses on histories whether primary or complicating, and also develop sufficient dispensary service to provide care for the ambulatory cases and the ambulatory stages of the cases treated in the hospital.

The final outline of the proposition for a committee to study the education and training of the hospital social worker was presented as developed by the negotiations authorized at the previous meeting of the trustees. The proposition was approved and the work will be carried on with financial support contributed from several sources.

The time, the traveling and other expenses of all members of the committee employed by organizations will be contributed by these organizations. Certain items of expense will be contributed by the New York School of Social Sciences and the rest of the fund required for special expenditures has been appropriated by the Russell Sage Foundation. The expense of organization and the overhead will be carried by the Association.

The desirability of a special committee to study the formal relation between states and cities to the hospital and dispensaries located therein was discussed and the following resolution passed:

Resolved, That the president be and hereby is authorized to appoint a committee of five to study the formal relations between states and cities to the hospitals and dispensaries located therein, and make due report to the Association.

By vote the trustees expressed approval of the distributing of exposition supplements as published by hospital magazines and containing complete programs from the registration booth at the Annual Conference.

It is the opinion of the trustees that the Association is making marked progress. The policy of service to the individual hospitals and the field in general has become the primary, the guiding and the fundamental one. The Association has reached the stage where it needs most of all intimate contact with and an official recognition by more hospitals.

The recognition needed is the formal one—of membership. The Association must officially represent more hospitals.

The more intimate contact needed is such as comes through use of the service of the Association and its service bureaus. By this both the Association and the hospital will benefit.

We ask that every member and hospital worker present undertake during the coming year to make a distinct contribution to the Association in each of the above lines.

DR. HOWLAND: I move that the report of the trustees as read be received and approved.

The motion was seconded and unanimously adopted.

THE CHAIR: We will now have the report of the Treasurer, Mr. Bacon. Mr. Bacon explains that this report will be given later, and we will pass to the report of the Membership Committee. Mr. Munger.

## REPORT OF THE MEMBERSHIP COMMITTEE

DR. C. W. MUNGER: This committee has considered and approved in the form all applications presented to it. The number of new members accepted in the past year and the totals representing membership in the Association are as follows:

### Institutional Membership

Institutional members on roll at last Conference....	310
New Members since last Conference.....	55
One member reinstated.....	1
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	366
Loss—Resigned .....	1
—Suspended for non-payment.....	7
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Total number in good standing.....	358
Increase for year 48, or 15 per cent.	

### Honorary Members

Total number of honorary members.....	10
No change in the past year.	

### Life Members

Life members on roll at last Conference.....	16
New Members since last Conference.....	15
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Present total .....	31
Increase, 93 per cent.	

### Active Members

Active members on roll at last Conference.....	875
New members since last Conference.....	274
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	1149
Resignations .....	67
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Number now on roll.....	1082
Increase for year 207, or 23 per cent.	

### Associate Membership

Associate members on roll at last Conference.....	187
New Members since last Conference.....	32
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	219
Resignations .....	15
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Total number now on roll.....	204

Increase for year 17, or 19 per cent.

Total number of personal members of all classes, 1,327.

While the increase in all classes of membership during the present year has been considerable, the committee is impressed by the small portion of hospitals and hospital workers in this country who are members of this Association, and believes that a large increase in membership is vital to the Association. Each present member should feel a distinct responsibility in this matter and during the coming year undertake to secure a substantial number of new members.

Accepted and approved.

THE CHAIR: Next is the report of the Service Bureau on Dispensaries and Community Relations by Mr. Michael Davis.

MR. MICHAEL M. DAVIS, New York City: Mr. Chairman, ladies and gentlemen: The Service Bureau on Dispensaries and Community Relations can present a report of the work from the last Convention, from the first of October until the present time, that is, for about eleven months. The work of the Bureau has been divided into, I might say, three parts. There is first the answering of inquiries received in writing or personally from the members of the Association or from others concerned with hospitals or dispensaries. The Bureau does not deal with matters of internal administration of hospitals or matters of hospital construction, but takes up, so far as hospitals are concerned, questions relating to the community relationships of the hospital. The most frequent questions have been perhaps those relating to the number of beds which a community needs, usually with reference to some possible extension of an existing hospital or to a change in the distribution of beds for various purposes, and the inquiries have come from members and non-members of the Association in fair proportion. There has been considerable correspondence, the full number of letters issued by the Bureau office in New York being approximately 720, of which approximately 300 have been personal letters and the remainder have been letters of a circular character sent out in answer to various inquiries. There have been fifty-one organizations or individuals representing organizations who have made inquiries of the Bureau. The organizations have been scattered all over the country. The inquiries in most cases have come in

writing. Some have required a short answer; some have required several letters, considerable study in the office and a fairly long report prepared and sent by mail.

#### CHARACTERISTIC DEFICIENCIES IN HOSPITAL SERVICE as Observed During a Year and a Half of Bureau Work:

As a result of surveys of hospitals of communities and of personal conferences and correspondence with representatives of many institutions, certain impressions of characteristic features or particular deficiencies in hospital work have appeared. The Bureau came into contact during the past eighteen months with over sixty institutions.

Perhaps the most frequent chronic disease of which hospitals complain is deflation of the pocketbook. The diagnosis of this disease generally requires neither a probe nor a microscope, but learning the cause of the disease is a very different matter. We must know the cause of this, as of any other ailment, before we can prescribe appropriate treatment, and to find the cause of the deflation of the hospital pocketbook may require a careful investigation before we find the portal through which the terrible germ, deficit, enters the hospital organism. Observation and study of many cases of the disease, deflation of the hospital pocketbook, has led to the conclusion that there is more than one cause for it. There is no one specific germ. Temporary cure can be promptly brought about by infusion of a sufficiently large bank account, but the tragic condition of deflation soon recurs unless one or another of its chief causes is discovered and eliminated.

Some of these causes are beyond the hospital's control; financial depression, for instance, or an increasing cost of maintenance due to general rise in wages and prices. At this moment there is no use discussing these causes, under which we have all groaned for some time. One financial disease germ which I have found frequently present and which is capable of being driven from the hospital organism by appropriate treatment, however, is worth talking about. The particular germ is a parasite known as "low rates." In many hospitals there has been observed an evident failure to adjust the rates charged patients in relation to the cost of service. What excuse is there for a hospital's crying for more money from the



public when it is charging \$28.00 a week for private rooms the weekly maintenance of which is between \$30.00 and \$35.00? What excuse is there for a hospital's crying for more money when it has daily per capita of \$3.50 and a ward rate of \$2.00, without any endowment to provide for the difference? The excuse is made that the hospital wants to do charity. Private patients should not be the objects of charity. There has been a growing demand for beds from people who are able to meet the cost of their care but not the cost of private room service. A great many hospitals have not adapted themselves to this demand and have sunk financially and morally as a consequence.

If we study out the manner in which the parasite of low rates has got into the hospital system, we will find that one of the portals of entry is the bookkeeper's office. The hospital accounts are not so kept that the proper rates can be definitely determined for each class of service and readjusted from time to time. What excuse is there for charging private patients less than the cost of their service to the hospital? What excuse is there for a hospital's being sick with deflation of the pocketbook when it has not kept its accounts so as to show as a monthly routine the amount of income and the cost of private patients separately from ward patients? It is to be admitted that the determination of cost involves certain elements of judgment as to the apportionment of various expenses, but experience has shown that it is possible to make this judgment, and business men on boards of trustees, and above all, people who are asked to give money to hospitals, should insist that hospitals show that they are charging proper rates before they are entitled to ask for money. To attack the disease of deflation of the pocketbook by closing the portal of entry of the parasite low rates will be to close one of the big sources of financial difficulty among the hospitals of the country.

In every hospital which has been studied, various technical deficiencies were found. That is true of all institutions. In almost every hospital one broad general deficiency has been observed; namely, the lack of a sense of responsibility to the community. There is a prevalent, indeed almost universal, sense of service to the individual patient; but the hospital is not usually thought of as an agency for serving the community. The trustees, the medical staff, and generally the superintendent look upon the hospital as run for some particular interest. Some-

times it must live up to the traditions of a memorial, or again it must meet the desires of certain doctors or certain contributors. Very few hospitals show any sense of studying out the needs of a community or of adapting their work from time to time to meet new needs as these arise with growth of population or because of a change in the character of the population. One example of this is the small extent to which different hospitals in the same community cooperate with one another or have any general plan for mutual assistance in community service. To a large extent the source of this difficulty is in the attitude of the medical staffs, many of whom regard the hospital as their special preserve, and the trustees and administrative officers tacitly acquiesce in making the hospital subservient to a certain medical clique. Another example of the lack of a community sense on the part of most hospitals is the failure to adapt the service to the needs of the middle classes who cannot pay for expensive private rooms but who want to pay at least the cost of their service. Most hospitals have been characterized either by subservience to the rich patient on the one hand or absorption in the idea of charity to the poor patient on the other. In order that large numbers of patients of the middle classes shall seek and find adequate hospital service, there will be required certain changes in the average hospital atmosphere, and a readjustment of hospital rates and of physicians' or surgeons' fees. Very few hospitals have been observed to be seriously undertaking this problem. There is a slow increase in the number of out-patient departments of hospitals, a slow increase in social service work and of relationships with health organizations, such as visiting nurses, but development in the direction of larger community service is too slow. There has been a good deal of talk about the hospital as a community organization, as a health center, but most of the hospitals observed have a long way to go before they know what these terms mean. The lay public is demanding more of the hospitals today than ever before, more service, particularly to the middle classes, and better service. Too many hospitals are behind the times in not perceiving that they can get from the public what they need if they will first give the public what the public desires. To determine what the public wants needs a study of community demands, requires that the hospital or its agents go outside their wards and learn what common people think about them,

what the outside lay and medical public are demanding and what they will pay for. These questions cannot be answered by sitting about within the hospital's own circle and talking of ideas not backed by community facts.

From the more technical standpoint of internal organization, the hospitals observed by the Bureau during the last year and a half have presented three characteristic defects. The most outstanding is improper organization of the medical staff. In the majority of non-teaching hospitals of moderate size, particularly in the smaller communities, and in some hospitals which do not fall into these categories, the institution is practically under the control of one doctor or of a handful of the physicians of the locality. Surgical influence is generally dominating. An effort to comply with the standards of staff organization laid down by the American College of Surgeons has been apparent in a good many cases and the effort is always beneficial; but in not a few instances, this compliance has been nominal. In fact, real compliance with these standards is impossible in the matter of staff organization, records and laboratory service alone, unless the rest of the hospital organization is also correct. It is easy to vote to have a staff organization, to have it meet once a month, to keep certain records, etc. But if the hospital trustees do not demand of the staff organization the outlining of definite professional standards; if the staff is unwilling really to back the superintendent or other authority in enforcing these standards upon all of its own members; if the staff meetings are full of factional issues instead of being devoted to clinic cases or real hospital business; if a few physicians of the locality continue to regard the hospital as their private preserve; if a single physician dominates the hospital's trustees through his influence or the number of cases he sends in—there cannot be an adequate medical organization. Excellent as the standards of the American College of Surgeons are, they relate to only very limited phases of the hospital, and with every credit to the valuable stimulus which the work of the College has brought to the hospitals of the country, it ought to be frankly recognized that the problems of the hospital should be approached from a broader standpoint than that of the College of Surgeons, and that the standards of the American College of Surgeons are in many cases impracticable, unless they are accompanied by other standards relating to other matters.

It is, for instance, essential that two other deficiencies frequently found in hospitals be corrected if the standards of the College with relation to the medical staff organization are really to be met. In many hospitals the organization of the board of trustees is fundamentally defective. There is division of authority between two boards, one of men and one of women. In a few hospitals as many as three different boards have been observed. The presence of members of the medical staff on the board of trustees is a diminishing custom but still found in many instances. Again, the duties of the superintendent and his relations to the board and to the executive committee of the medical staff are often ill defined. Several hospitals have been observed in which the authority of the superintendent is entirely inadequate, in which there is division in control of administration among several officers. In a few instances, hospitals have proceeded from the stage of dispersion of authority into one of over-centralization of authority in the hands of the superintendent. Here is found an over-balanced organization, with the result of arbitrary exercise of power. But a much more characteristic evil at present is an inactive board of trustees, or a division of authority among different boards, with the powers of the superintendent inadequate and ill defined, and the effective control of the hospital in the hands of one or two of the medical staff. There is very little use in talking about hospital standards from the standpoint of the surgeon, or of the medical staff, or of the record room, or of the out-patient department, or of the nurses' training school, unless we first have the proper organization of the trustees and the superintendent in their relations to all other parts of the hospital system. The stimulus given to certain phases of hospital service and to staff organization by the American College of Surgeons seems to me to require that this stimulus be now given a sound and firm foundation by the action of some authoritative national body, such as the American Hospital Association, defining and giving great publicity to general standards of organization, particularly those relating to boards of trustees and to the duties and relations of superintendents.

To sum up these more or less rambling observations:

1. The hospital's prevalent disease of deflation of the pocketbook must be dealt with by various methods of treatment, but can generally be relieved, if not removed, by the adjustment of hospital rates to the cost of services,

particularly that for private rooms. This requires more accurate hospital accounting than is prevalent today, and such accounting should be demanded by the contributing public. The increased use of hospitals by the middle classes should assist the hospitals financially, if they will study community needs and adjust service and rates accordingly.

2. Most hospitals are too much shut up within a circle of special interests. They need to become more studious of community needs, more responsible to community problems. When they reach that stage they may then perhaps expect generous measure of community support.

3. There are prevalent deficiencies in hospital organization and in the exercise of effective and intelligent control by the board of trustees acting through the superintendent and the staff. These deficiencies are interdependent and cannot be removed by dealing with medical staff organization alone or with the trustees or superintendent alone.

4. The promulgation of general hospital standards by some authoritative national body, now a pressing need, is made more urgent because of the authority of the special and limited standards already spread broadcast by the American College of Surgeons.

THE CHAIR: You have heard this report. What is your pleasure? Unless there is objection, the report will be accepted and approved. Next is the report of the Service Bureau on Hospital Social Work,\* by Miss Ida M. Cannon.

MISS CANNON: The committee appointed by the American Hospital Association in 1920 to make a survey of hospital social work in the United States and Canada stated in the conclusions of its report that:

“(a) It is desirable that the fundamental principles of function, policy, and organization of social service in hospitals and dispensaries should receive the official endorsement of national bodies concerned with these fields of service.

(b) It is desirable that there be some active central agency, officially close to hospitals, for the practical dissemination of these principles, the further development of

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\*This report covers the work of the bureau from October, 1920, to October, 1921.

standards and record keeping and the advice and guidance of those concerned with the initiation or conduct of social service departments.

(c) It is essential that the function of social service be clear in the minds not only of those who practice it professionally but also of the trustees, the superintendents, and the medical staffs of hospitals and dispensaries."

On October 8, 1920, at the meeting of the trustees of the American Hospital Association, it was voted to authorize "the establishment of a Service Bureau on Hospital Social Work in cooperation with and with the moral support of the American Association of Hospital Social Workers for the aid and development of social work in hospitals and dispensaries."

On December 4, 1920, I received official notification of my appointment as director of the bureau.

A bulletin was prepared by the director and sent in January by the executive secretary to all members of the American Hospital Association. These were also distributed at the information booth of the American Association of Hospital Social Workers at the time of the American Medical Association meeting in June and at the American Hospital Association meeting in September, 1921.

The bureau has been chiefly concerned with:

1. Correspondence with hospitals and individuals seeking advice.
2. Interviews with hospital superintendents, physicians, hospital social workers and representatives of social agencies.
3. Securing material for a directory of hospital social service departments in the United States and Canada.

The questions that have been raised in the interviews and correspondence may be summarized as follows:

A. Organization—

Make-up of advisory committees.

Relation to social agencies outside.

Placing of first social worker, i.e., how to begin.

B. Personnel—

Workers wanted for departments.

Positions wanted.

Advice in training.

C. Recording—

Request for sample forms.

Forms submitted for criticism to Chief of Bureau.



D. Bibliography—

Special reading desired.

E. Medical follow up method.

F. Information concerning special types of hospitals having social service.

G. Relation of social service departments to training schools for nurses.

H. General information for those contemplating starting a department.

While the requests have not been numerous, they have clearly revealed a need for more careful thinking on these subjects, more careful analysis of the functions of social service, more discriminating literature, and especially the importance of better training for hospital social workers.

Effort has been made by the Chief of the Bureau to meet some of these needs by suggesting the presentation at the meeting of the American Hospital Association, and discussion with authors of two papers on social service in relation to clinical medicine and to dispensary administration; by preparing a brief bibliography pending the publication of the more extended one by the American Association of Hospital Social Workers; by serving on the committee on training of hospital social workers.

There is evidently a very real need to consider and formulate a program for social service in the smaller hospitals where visiting nursing is often an important part of the community service of the hospital.

I wish to recommend that the bureau look to the American Association of Hospital Social Workers for standards that are accepted by the professional group. For instance, I should suggest that the American Association of Hospital Social Workers appoint a committee on record forms to work jointly with the bureau on social service record forms that would be helpful to those inquiring for such.

Another important matter to be threshed out is the relation of social service departments to other social agencies in the community. There is great need for clarifying these relationships. The bureau has urged the executive committee of the American Association of Hospital Social Workers to study the methods of cooperation now in practice and to consider means of better correlation of social service in hospitals and that carried on by other social agencies in the community.

Letters have been sent to all hospitals known to have social service departments and to all hospitals represented in the membership of the American Hospital Association. A directory containing this information is now being classified according to types of hospitals and will be useful later in circularizing such departments. A copy of this catalog will be filed at the Hospital Library and Service Bureau.

It was a great satisfaction to get the letters from hospital superintendents all over the country when returning the card for the directory. The cordial attitude of these hospital administrators gives promise not only of usefulness for the bureau but also for the future of hospital social work in this country.

THE CHAIR: If there is no objection, the report of Miss Cannon on the Service Bureau on Hospital Social Work will be accepted and approved. We will now have the report of the Executive Secretary, Dr. Warner.

## REPORT OF THE EXECUTIVE SECRETARY

The reports of the trustees, of the treasurer, of the membership, of the standing and the special committees and of the service bureaus have given you the important accomplished facts concerning the work of the Association as done in the past year. It is, therefore, proper that this report make critical comments thereon and tell you of that which was not done or not well done, of the things that are as yet only plans or hopes, and to forecast for you a future of attainable progress.

The membership has grown somewhat in numbers in all classes as is shown in the report of the Membership Committee. But it has grown more in ways other than in members.

It is evident that the hospitals now regard their institutional membership as of greater value. Only \$295.90 is yet unpaid of the 1921 dues and the total effort expended has been to send quarterly bills. Not a letter has been written. This includes the recent applications on which bills for dues have not been sent. It is better recognized than heretofore that such membership is a contract between the Association and the responsible owners of the hospital.

There has been temptation to start an active correspondence campaign for institutional memberships. But the contrast in the attitude toward the Association be-

tween some of the older members and all of the newer members was too striking to permit haste. The basis of this is the fact that the older members joined to help the Association in its organization and the newer members have joined to help themselves in their work. Some of the earlier members are still primarily helping the Association but the latter are now primarily getting help from the Association.

Perhaps this cannot and should not be changed and the Association certainly did need and still needs and appreciates highly the help, but it makes one hesitate to interfere with the present situation. The new members we are now gaining mean too solid a growth to risk any change. The new institutional members are coming in largely as a result of some service from the Association or contact with other members, and from the first they ask enough service from the Association to answer for themselves the question as to "what they are getting for their membership dues." Would a membership campaign produce so healthy a growth?

The Association can never compel any hospital to ask or use our services or to do anything. We can only offer, and by bulletins and otherwise acquaint the hospital with facts, arguments and the ways of other institutions. But we are naturally surprised when a hospital does not find even a question to ask of the resources of the Association, and naturally wonder if that hospital as yet realizes the recent developments, and that the full time executive secretary—once so important—is now only a very small part of the organization active and available throughout the year.

While the Personal Membership lists are somewhat larger in number, they are markedly different in quality. The quarterly bulletins keep the addresses correct. Inquiries and correspondence keep the record up to date. Regular quarterly bills and a more active interest in the Association keep the dues better paid. Personal members are in the main appreciative as to the value of the service available to them. This adds value in the memberships to us.

The striking feature to be mentioned is the greater number of trustees taking out personal membership. Institutional membership was expected to secure their interest and enable the Association to reach trustees. Perhaps it has had some effect in this way, and the increase in personal membership is a result of this. But it is now

quite clear, and perhaps logical, that many trustees wish to receive their information directly to be used for the guidance of the hospital rather than that it be received through the hospital and used for their guidance. The educational service of the Association to trustees must develop much and soon.

Nothing is so disheartening as to receive an official hospital check paying the personal membership dues of the superintendent. The failure of the Association and the attitude in that hospital is so evident. We have the five dollars and that is about all. We do not have an active personal member in any sense of those words. We do not have one more hospital feeling itself a part of or presuming to participate in the activities of the Association. We have only ourselves to blame for this—the Association has miserably failed to get over to that superintendent the basis of our work and our aims. The money is without question useful, but money alone will never make this Association able both to serve and to lead. The other factors absolutely essential are acting brains, thoughtful policies and human effort, and these do not come with official hospital checks paying personal memberships.

The income from personal membership is growing, but the cost of printing and other services to personal members as individuals is amounting to as much as the dues. This is as it should be. Personal memberships cannot and should not support overhead or advancements.

The larger increase in the income from the institutional membership is supporting the development of the organization of the Association *as a machine to perform service* to them as individual hospitals and to the field. the opportunities to extend and to better this service in a thoroughly wise and conservative way are, however, developing faster than the income grows.

We need more money. The raising of a fund to make an extended service possible at once has been proposed. The returns from such an investment in the advancement of the hospital field certainly would be remarkable. On the other hand, why is it taking the hospital so much longer than other fields to realize that the benefits from organization are certain and all out of proportion to the cost of any membership dues? Your executive secretary has refused to believe that this will long remain the situation. Why is your hospital not now a member—if it is not? Can we not do a little more for ourselves before we appeal for aid?

Funds to support special investigations have become available as rapidly as definite propositions have been developed and we were able to show a fitness for the work. This will continue. As the Association becomes stronger and more able to do special work, more financial support for such work will appear.

The Annual Conference was planned to be of the utmost value to delegates who had come to learn and to get help in the form of facts, figures, and suggestions. Everything was considered in the light of its service value.

The exposition is just twice as large as last year but of many times the value to delegates—if they will take the time to see what is there. As soon as delegates generally realize the possibilities of service to them from the exposition and will make a point of knowing what is exhibited therein each year, our exposition will become the established means of introducing to the hospital field the new and the improvements in equipment and materials. The great value of such an exhibit in connection with each annual gathering, cannot, I believe, be questioned. Whether we get it or not is all up to you and your attitude toward the exposition. The reliable, larger, and the established corporations, which we most desire present, will not come or continue to come into an atmosphere of indifference or toleration. But they will be glad to come to meet users of equipment such as they manufacture, for mutual suggestions, criticisms and discussions.

The fundamental policy of service to our members and to the field has in the past year become more definite and better understood. It is now more clearly seen as the only policy which fully justifies the continued existence of the Association and progressive growth.

The work of the year has contributed much to the strength and system of our organization for service. It is now evident that it takes time to get a service bureau into action, or the Chicago office ready to handle a new line of inquiries, but the past year has been thus utilized. Each of our bureaus has worked out affiliations and connections with other organizations which eliminate duplications and which secure routine assistance of an expert nature. Each is, therefore, now better able to give final authoritative opinions which are in fact a consensus of expert opinions. It takes time to develop this organization. It also takes time to make this generally known and to establish the subconscious suggestions whereby ques-

tions are promptly asked of the bureaus instead of some acquaintance.

The Service Bureau on Dispensary and Community Relations has now become quite active and filling the function for which it was designed. It has been pleasing to note the high personal qualifications and the satisfactory work done by the persons secured by the director to make the field studies in the surveys made. The surveys to be made under the direction of this bureau will increase during the next year and the Association must soon face the necessity of retaining the service of one or more of these persons throughout the year.

The surveys made by this bureau and listed in its report have done much to advance the prestige of the Association.

The Service Bureau on Hospital Social Work is newer and, therefore, has less accomplishment to report, but it is now ready and able to give you real service—for the asking.

There is a need for a service bureau organized and equipped to analyze construction problems and give sound advice. We are pleased to believe that there is now at least a possibility of having in the near future such a bureau on construction and one that will be a credit to the Association.

The development of state sections has brought to us the responsibility for acting at least as a clearing house and source of information of state legislation affecting hospitals. We should also be able to assist by dispensing information as to the laws in other states and take active part in combating such vicious bills as the legal open staff bills.

A compilation and extraction of all existing state laws affecting hospitals is available at a price and at reasonable cost this could be kept up to date. If to this was added a director capable of mapping out a legislative campaign and providing the state association with the legal and other material for the same, much could be accomplished for the hospitals of many states. But the Association now lacks the funds necessary for this work.

As the Association has become more active throughout the year the committees have become more active and available to the office and to members for advice, data, and work.

The special committees have been appointed as the need for and the funds to support special work appeared.



Five are making progress, or final, reports at this Conference. Their reports speak for themselves. The cost of their work to parties other than the Association will be in excess of \$20,000.

The policy of sending timely and useful information in the form of bulletins to institutional members has been continued and may now well be considered a permanent practice. There is constant call and use for these bulletins requiring new editions. Three have now gone over the five thousand mark. It has also become easier to get valuable data for publications in these bulletins.

The quarterly bulletins to personal members keeping them informed as to the Association seems to meet with general approval.

Correspondence is growing. The Chicago office alone expended for postage this year \$890.62, compared with \$613.96 the year before—an increase of 44 per cent. Much of this correspondence means service.

Next year all the above service will be continued and made better by the normal development of a working organization and, we hope, by greater use.

New features will also be added to the limit of the available funds.

The Association is not duplicating the work of the Library but rather using it freely and contributing substantially both to the subject matter filed and to its maintenance. The function of this library maintained by the American Conference on Hospital Service is to collect and dispense data on all subjects related to hospital work without comment or opinion. We ask that members contribute to the collection of information, data, and literature and also use the Library to furnish them with facts. The more it is used the more and better will be the information filed and given out.

Perhaps it is appropriate to state here facts and to state them plainly, for all implied criticism is of ourselves.

During the past year your executive secretary has given considerable thought to an analysis of his job and of the Association. The most urgent part of this job right now seems to be principally one of expanding and building up the organization of the hospital field in time to meet recently developed conditions and external forces now impending.

In contemplating the size of the hospital field of the United States and Canada measured either on the basis of dollars or on the basis of the human elements one

is astonished. A realization of the importance of it to every citizen of this country as an individual and to humanity in general is overpowering. The need for extension, improvements and help in many ways is pitiful. But a comparison of this field and these opportunities with the strength and the accomplishments of the American Hospital Association makes our failure only the plainer.

I know I have worked as I know my predecessors have worked—hard to the same end, but results have been so meager. After three years work less than five per cent of the hospitals are institutional members of the Association. After twenty-two years of work less than one per cent of the people eligible to *active personal membership* are on our rolls.

There is no occasion for us to be proud of ourselves in any way. We cannot compare favorably with the organization of any corresponding field and are scarcely one-tenth of what we should be to pass as even a satisfactory organization.

We must recognize that hospitals are yet fundamentally local charities with a tendency toward isolation as strong as the tendency of humanity toward wickedness and we must be patient, but we believe that both the tendency toward isolation and the tendency toward wickedness alike are best checked by the development of ideals, of personal pride, and of a knowledge of good standards. All this is necessarily based on contact with each other. Somehow the Association must penetrate even the last isolation—which justifies a policy of action.

During the past year there has been ample evidence that we are generally regarded as the official organization of the hospitals and the parent of all other hospital organizations. We still have the opportunity. Will we use it, or continue to let matters drift? We must recognize that there is now clearly marked evidence that the opportunity will not be before us forever.

The dangerous possibilities from a division of the field and the development of various hospital associations representing various elements has already appeared—a vital enemy to the development of an organization large enough and strong enough to serve and to lead.

We are now seeing other organizations undertaking work we should have done. When the American College of Surgeons determined to do something to better surgical practice it was promptly recognized that certain hospital betterments were essential—so essential that the program

is now referred to as the Standardization of Hospitals. We have wished them all success in their work, but we are sorry we did not clean house before others had to come in and do it for us.

One year ago the trustees of the American Medical Association seriously considered a strongly backed proposal to create a Council on Hospitals. They compromised by making the Council of Medical Education, the Council on Medical Education and Hospitals. The point of entry into hospitals by the American Medical Association is medical education and properly so, and the question is—how far will they find it necessary to go to get things done that obviously should be done.

The moral as well as financial support generally given to the College of Surgeons should be lesson enough for the hospitals. We should by this know that there is ample financial and public support back of any sound program for the betterment of hospital service to see it through, regardless of any internal difference or opposition.

Three of our departments have organized their fields miles in advance of the hospital field—the nurses, the social workers and the dietitians—to say nothing of the medical organization or other fields reaching into the hospital from the outside.

Shall we remain content with this situation? Will we be really satisfied with all the decisions on the many important hospital questions now pending with no greater influence and no greater participation therein than we now have?

The real situation is that our opportunities have been and yet are great, while our accomplishments have been few; also that the concerted efforts of those here assembled can accomplish much in the development of the hospital field and to the credit of the Association if we all work and work together.

Opinion and practice is now unified to a point that will permit the Association to formulate standards for the organization of the hospital down to and including the superintendent. The standards of staff organization as formulated by the College of Surgeons are now generally accepted and would undoubtedly be included.

The benefits to be derived by the hospital field from this are incalculable as it would determine the character of the additions to the field and gradually bring existing institutions into harmony. More questions as to hospital

organizations are now coming to the Chicago office than on any other subject.

All that is required is that we be strong enough and feel ourselves strong enough to put this over, then to go at it. The strength of the organized few against the unorganized many will do the rest.

We can also get existing formulated standards into more general use—the standard for staff organization, for professional work, for the training of interns, for nursing education, for hospital social work, for the compilation of statistics, and others, can yet count for progress in practically all hospitals. Get all that there is in them out for your hospital.

The report of the committee studying the recording of all phases of hospital activity will be presented to this Conference in a form so that its general adoption would standardize many hospital figures and statistics. Is there any organization better qualified than ourselves to formulate these standards? Will we receive, develop, and establish this report as setting standards or will we wait until some association of accountants or statisticians writes these standards for us?

There are unlimited opportunities for constructive work and action—opportunities far beyond the capabilities of the present organization just in front of us. And we have scarcely touched the resources of the field.

The past of the Association is a fixed record, but the future will be what you make it. The next year will be practically predetermined by the attitude, the convictions and the plans of work with and for the Association which you will carry away from this Conference.

THE CHAIR: You have heard the report of the secretary; if there is no objection, it will be accepted and approved. I have to announce two committee appointments, Dr. A. C. Bachmeyer of the Cincinnati General Hospital, Sister Geraldine of Youngstown, and Mr. R. E. Knapp, as the Committee on Resolutions.

To fill the vacancies caused by the absence of Mr. Borden and Dr. Seem, on the Committee on Constitution and Rules, I would name Dr. Peters of Providence and Dr. Howland of Boston, to serve during this session, in the absence of the regular members. We will now listen to the paper entitled "Salaries Hospital Superintendents Are Now Receiving," by Mr. Joseph J. Weber, managing editor of "The Modern Hospital."

MR. DANIEL D. TEST: May I say a word before we pass away from these reports? If we were living under the old dispensation of an eye for an eye and a tooth for a tooth, I think we would all want to make it hot for the trustees, including our secretary, for bringing us to this very delightful place in hot weather, but since we are under a new dispensation, I do not want this occasion to pass without saying that I believe I voice the feeling of us all when I express my appreciation of the work done by our officers during the past year. Whether or not we agree with all they have done, they have done an immense amount of work for our benefit. There is just one thing in the trustees' report to which I did not want to refer until after the report was accepted, and that is in reference to publishing the annual report without sending the discussions to the individual members for editing. We have a most excellent reporter, but many persons are difficult to follow and many others cannot speak extemporaneously as understandingly and helpfully as they can write. If some of the remarks which I made at the meeting in Montreal last year were really as crazy as they are portrayed in the annual report, I hope my friends will be spared from ever having to listen to me again. If the discussions are worth publishing at all, they ought to be in the most helpful form.

MR. WEBER: In speaking of salaries, maintenance is included where maintenance constitutes part of the salary, and I have had to accept the monetary estimates of the superintendents who have sent me the data.

To secure the information on which this paper is based, questionnaires were mailed to two groups of hospitals. One group consisted of hospitals having less than 100 beds; the other, of hospitals having 100 beds or more. Of the smaller hospitals, i. e., hospitals of less than 100 beds, 500 were selected from the country at large. In order to secure information that would represent every section of the United States, these 500 hospitals were distributed among the various states in the ratio which the population of each state bears to the total population of the United States, according to the Federal census of 1910. To illustrate, the population of New York State, approximately 10,000,000, is roughly one-tenth of the total population of the United States. New York State was, therefore, represented in the list to whom the questionnaire was sent by one-tenth, or fifty, of the total 500 hospitals. This principle was followed in distributing

the entire 500 hospitals among the various states. By this method it was hoped to obtain, as nearly as possible, representative information of the salaries paid the superintendents of the smaller hospitals in every section of the country. Of these 500 institutions, 112, or 22 per cent, responded to the questionnaire.

The second group, i. e., hospitals of 100 beds or more, consisted of the 285 non-Catholic hospitals in the American College of Surgeons' 1920 list of approved hospitals. The hospitals in this list are widely distributed, not only throughout the United States, but also throughout Canada. Of these 285 institutions, 116, or 40 per cent, responded to the questionnaire.

For the purpose of analyzing and comparing the salaries received by the executives of these hospitals, we have divided the 112 hospitals in the first group into the following three subdivisions:

1 to 49 beds; 50 to 74 beds; 75 to 99 beds.

The 116 hospitals in the second group, ranging in capacity from 100 to 2,700 beds, we have divided in the following subdivisions:

100 to 199 beds; 200 to 299 beds; 300 to 399 beds; 400 to 499 beds; 500 and more beds.

First of all, it must be admitted that the principle of equal pay for equal service does not find general application in the salaries of hospital superintendents. Women, on an average, receive lower salaries than men superintendents. To present averages of the combined salaries of men and women would, therefore, give an exceedingly false impression of the situation; on the one hand, reducing the average salaries of the men, and on the other hand, increasing the average salaries of the women. The salaries of men and women superintendents will, therefore, be dealt with separately.

As was to be expected, women predominate as superintendents of the smaller hospitals, there being eighty-nine women to twenty-three men; while men predominate as superintendents of the larger institutions, there being eighty-five men to thirty-five women. Twenty-five of these thirty-five women, moreover, are superintendents of hospitals of 100 to 199 beds, the group that lies just above what we choose to call the smaller hospitals, i. e., institutions having less than 100 beds.

One of the most interesting things revealed by this study is the fact that in many of the subdivisions a relatively small number of superintendents receive sal-



aries that are above the average salary for their subdivision, while a relatively large number receive salaries that are lower than the average salary for their subdivision. This is true of both men and women superintendents. In the fifty to seventy-four bed subdivision, for example, the salaries of forty-three of the fifty-six women are below the average. In the 100 to 199 bed subdivision, the salaries of sixteen of the twenty-five women and fourteen of the twenty-five men are below the average.

The highest salary paid a woman superintendent among the 228 hospitals from which information was secured, is \$5,400, the executive of a 150 bed hospital; the lowest, \$1,200, the executive of a ninety bed hospital. The highest salary paid a man superintendent is \$18,000, the executive of a 485 bed hospital; the lowest, \$1,740, the executive of a sixty bed hospital.

The superintendents of but two of the smaller hospitals receive \$5,000 or more. Among the larger hospitals, 46 per cent of the superintendents receive \$5,000 or more.

The average salary of the women superintendents in the three subdivisions of the smaller hospitals ranges from \$2,220 to \$2,530, the minimum individual salary being \$1,200, the maximum \$4,000.

Of the thirty-one women superintendents of the larger institutions, twenty-five, as already indicated, are superintendents of hospitals with a capacity of from 100 to 199 beds, and receive an average salary of \$2,899; five are superintendents of hospitals with a capacity of 200 to 299 beds, and receive an average salary of \$3,795; and one is the superintendent of a 471 bed university hospital, and receives a salary of \$3,484.

The average salaries of the eighty-five men superintendents in the various subdivisions of the larger hospitals range from \$4,650, paid the superintendents of hospitals of 100 to 199 beds, to \$7,604, paid the superintendents of hospitals of 400 to 499 beds.

If you are the superintendent of a hospital supported by private funds, as distinguished from a municipal or county hospital, your salary is likely to be more lucrative than if you are the superintendent of a hospital supported by the public treasury. For instance, the average salary of the twenty-two men superintendents of the hospitals supported by private funds in the 200 to 299 bed subdivision, is \$1,577 more than the average salary of the super-

intendents of the five city and county hospitals in this subdivision; \$2,000 more than the average salary of the superintendents of the three city and county hospitals in the 300 to 399 bed subdivision, and \$776 more than the average salary of the superintendents of the largest city and county hospitals in the United States.

To come to any constructive conclusions from a study of this rather diversified data is not easy. This fact, however, is plainly evident: there is no approach to standardization; indeed there is no evidence to indicate the recognition of even minimum standards for the superintendents of institutions of various capacity and character of service. Some superintendents receive relatively high salaries, while many others, who serve hospitals of like capacity and service, are receiving much less. For example, the difference between the minimum and maximum salaries among the men superintendents of the 100 to 199 and the 200 to 299 bed groups is about \$9,000; in the 400 to 499 bed group, about \$15,500, and in the group of 500 beds and over about \$6,000.

We found ourselves somewhat at a loss to find a basis upon which to compare the salaries of hospital superintendents with the salaries of those in other professional fields. Perhaps the position of hotel manager approximates more closely than any other the position of the superintendent of a hospital, although one must not forget that the superintendent, in addition to performing all the duties of a hotel manager, has certain other, often difficult, duties that are inherent in the management of an institution devoted to the care and treatment of the sick, and for the acceptable performance of which he can qualify only after prolonged training and experience. So far as we are aware, no systematic attempt has ever been made to study the salaries of hotel managers, by and large. From the meager information available, it seems that the salaries of hospital superintendents, in many instances, compare favorably with the salaries paid the managers of hotels. We are informed by the editor of one of the leading hotel journals, that from \$3,000 to \$4,000 and maintenance is now regarded as a fair salary for the manager of a hotel of average size; and that salaries of \$5,000 and \$7,500 are exceptional, and are paid managers of the largest metropolitan hotels.

DETAILED INFORMATION REGARDING SALARIES PAID SUPER  
INTENDENTS OF 112 HOSPITALS HAVING LESS  
THAN 100 BEDS

Range of Bed Capacity of 112 Hospitals—20 to 97 Beds.

*1 to 49 Bed Group*

Twelve hospitals, or 11 per cent, of 112 hospitals under consideration.

Number of men superintendents.....	4
Number of women superintendents.....	8
*Average salary of women superintendents.....	\$2,220
Minimum salary of women superintendents.....	1,500
Maximum salary of women superintendents.....	3,210
Salaries below average.....	2
Salaries above average.....	4
**Indeterminable .....	2
Average salary of men superintendents.....	\$2,445
Minimum salary of men superintendents.....	1,800
Maximum salary of men superintendents.....	3,000
Salaries below average.....	2
Salaries above average.....	2

*50 to 74 Bed Group*

Sixty-six hospitals, or 59 per cent, of 112 hospitals under consideration.

Number of men superintendents.....	10
Number of women superintendents.....	56
Average salary of women superintendents.....	\$2,530
Minimum salary of women superintendents.....	1,500
Maximum salary of women superintendents.....	4,000
Salaries below average.....	43
Salaries above average.....	7
Indeterminable .....	6
Average salary of men superintendents.....	\$2,316
Minimum salary of men superintendents.....	1,740
Maximum salary of men superintendents.....	3,000
Salaries below average.....	5
Salaries above average.....	5

*75 to 99 Bed Group*

Thirty-four hospitals, or 30 per cent, of 112 hospitals under consideration.

Number of men superintendents.....	9
Number of women superintendents.....	25
Average salary of women superintendents.....	\$2,492
Minimum salary of women superintendents.....	1,200
Maximum salary of women superintendents.....	3,600
Salaries below average.....	16
Salaries above average.....	9
Average salary of men superintendents.....	\$3,827
Minimum salary of men superintendents.....	2,400
Maximum salary of men superintendents.....	5,600
Salaries below average.....	6
Salaries above average.....	3

\*Where maintenance constitutes a part of the compensation, its estimated monetary value is included.

\*\*Indeterminable because maintenance was not estimated in dollars and cents.

DETAILED INFORMATION REGARDING SALARIES PAID SUPER-  
INTENDENTS OF 116 HOSPITALS HAVING 100  
OR MORE BEDS

Range of Bed Capacity of 116 Hospitals—100 to 2,700 Beds.

*100 to 199 Bed Group*

Fifty hospitals, or 43 per cent, of the 116 hospitals under consideration.

Number of men superintendents.....	25
Number of women superintendents.....	25
<i>Average salary of women superintendents.....</i>	<i>\$2,899</i>
Minimum salary of women superintendents.....	1,260
Maximum salary of women superintendents.....	5,400
Salaries below average.....	9
Salaries above average.....	9
Indeterminable .....	7
<i>Average salary of men superintendents.....</i>	<i>\$4,650</i>
Minimum salary of men superintendents.....	2,040
Maximum salary of men superintendents.....	11,500
Salaries below average.....	12
Salaries above average.....	11
Indeterminable .....	2

*200 to 299 Bed Group*

Thirty-two hospitals, or 28 per cent, of the 116 hospitals under consideration.

Number of men superintendents.....	27
Number of women superintendents.....	5
<i>Average salary of women superintendents.....</i>	<i>\$3,795</i>
Minimum salary of women superintendents.....	2,865
Maximum salary of women superintendents.....	4,620
Salaries below average.....	2
Salaries above average.....	1
Indeterminable .....	2
<i>Average salary of men superintendents.....</i>	<i>\$6,716</i>
Minimum salary of men superintendents.....	3,000
Maximum salary of men superintendents.....	12,000
Salaries below average.....	13
Salaries above average.....	11
Indeterminable .....	3

*300 to 399 Bed Group*

Five hospitals, or 4 per cent, of the 116 hospitals under consideration.

Number of men superintendents.....	5
<i>Average salary of men superintendents.....</i>	<i>\$4,850</i>
Minimum salary of men superintendents.....	4,200
Maximum salary of men superintendents.....	5,500
Salaries below average.....	2
Salaries above average.....	3

*400 to 499 Bed Group*

Twelve hospitals, or 10 per cent, of the 116 hospitals under consideration.

Number of women superintendents.....	1
Number of men superintendents.....	11
<i>Average salary of men superintendents.....</i>	<i>\$7,604</i>
Minimum salary of men superintendents.....	2,400

Maximum salary of men superintendents.....	18,000
Number whose salary is below average.....	6
Number whose salary is above average.....	4
Indeterminable .....	1

*500 Beds and Over*

Seventeen, or 15 per cent, of the hospitals under consideration.

Number of men superintendents.....	17
Average salary of men superintendents.....	\$6,962
Minimum salary of men superintendents.....	4,100
Maximum salary of men superintendents.....	10,250
Salaries below average.....	7
salaries above average.....	7
Indeterminable .....	3

**SALARIES OF SUPERINTENDENTS OF 112 HOSPITALS HAVING  
LESS THAN 100 BEDS**

No. of Beds	Sex of Super- intendent	Monetary Salary	Monetary Equivalent in Board, Room and Laundry	No. of Beds	Sex of Super- intendent	Monetary Salary	Monetary Equivalent in Board, Room and Laundry
<i>1 to 49 Bed Group</i>							
20	F	\$1,800	\$360	36	M	\$1,800	0
30	M	2,700	0	36	F	1,500	Not established
30	M	3,000	0	50	F	2,400	\$800
33	F	1,500	360	40	F	1,800	480
35	F	1,800	Not estimated	40	M	1,800	480
35	F	1,360	480	45	F	1,800	360
<i>50 to 74 Bed Group</i>							
50	F	\$1,800	\$1,200	60	M	\$1,800	\$ 780
50	F	1,320	0	60	F	1,400	500
50	F	1,800	600	60	F	1,800	600
50	F	1,500	540	60	F	1,320	600
50	F	1,800	0	60	M	1,740	0
50	F	1,800	780	60	F	1,500	600
50	F	1,500	525	60	F	1,500	0
50	F	1,800	1,680	60	M	2,160	0
50	F	1,800	360	60	F	3,000	720
50	M	1,500	400	60	F	2,000	1,000
50	F	1,500	0	60	M	2,700	260
50	F	1,500	480	62	F	1,800	260
50	F	2,500	1,500	65	F	2,100	Not estimated
50	F	1,500	1,200	65	M	2,520	0
50	F	1,800	500	65	F	1,800	416
50	F	2,400	900	65	F	2,100	Not estimated
50	F	1,500	Not estimated	65	F	1,800	365
50	F	1,500	Not estimated	65	F	1,800	700
50	F	1,800	480	65	F	2,400	1,560
50	F	1,200	600	65	F	1,980	1,020
50	F	1,200	540	66	F	2,100	900
50	F	2,400	780	68	F	1,800	480
50	F	1,500	600	70	F	1,500	300
52	F	1,800	600	70	M	2,400	360
52	F	1,800	Not estimated	70	F	1,500	480
52	..	44,520	15,345	70	F	1,500	365
54	F	1,800	300	70	F	3,000	Not estimated
54	F	3,600	0	70	F	2,700	0
55	F	1,680	480	70	F	1,500	900
56	F	1,800	480	70	F	1,800	0
56	F	1,800	480	70	M	1,200	540
57	M	3,000	0	70	M	2,100	600
60	F	1,500	384	72	F	1,800	600

No. of Beds	Sex of Superintendent	Monetary Salary	Monetary Equivalent in Board, Room and Laundry	No. of Beds	Sex of Superintendent	Monetary Salary	Monetary Equivalent in Board, Room and Laundry
<i>75 to 99 Bed Group</i>							
75	F	\$1,800	\$ 360	80	F	\$1,800	0
75	F	2,000	780	82	F	1,800	\$ 500
75	M	1,800	600	85	F	2,000	960
75	F	1,500	0	85	M	3,600	1,200
75	F	1,080	360	86	M	5,000	0
75	M	5,000	600	86	M	3,000	0
75	F	2,400	750	87	F	2,400	0
75	M	2,400	780	87	F	3,000	600
75	F	1,500	600	88	M	2,500	0
75	F	2,000	600	90	F	1,200	0
75	F	1,500	365	90	F	2,000	0
75	F	1,800	720	90	F	1,800	720
75	F	1,800	0	90	M	2,700	150
80	F	1,500	720	90	F	1,800	900
80	M	2,100	900	90	F	2,400	720
80	F	1,500	Not estimated	90	F	2,400	200
80	F	1,800	0	97	F	1,380	720

### SALARIES OF SUPERINTENDENTS OF 116 HOSPITALS HAVING 100 OR MORE BEDS

<i>100 to 199 Bed Group</i>							
100	F	\$1,500	B., R. and L.	150	M	\$3,000	\$ 600
100	F	2,250	Not estimated	150	F	2,200	1,440
100	M	3,000	1,800	150	F	1,800	600
100	F	900	360	150	F	4,500	900
100	M	3,000	0	150	M	7,500	0
101	M	4,500	0	150	F	3,000	Two Rms., bath
110	M	8,500	3,000	150	M	3,600	1,400
115	F	1,560	660	150	M	5,000	480
119	F	2,400	900	150	M	2,580	730
120	M	2,500	0	150	F	2,700	Two Rms., bath
120	F	1,800	780	150	F	2,300	360
125	M	4,000	960	150	F	2,400	500
125	F	1,680	660	150	F	2,400	600
125	F	2,000	540	150	M	2,700	700
125	M	4,500	0	155	M	6,000	0
125	F	2,400	480	160	F	2,100	B., R. and L.
135	F	2,100	0	160	F	2,000	416
137	M	6,000	1,000	160	M	3,600	0
140	M	3,000	2,000	170	M	5,000	0
140	F	2,400	600	170	M	2,500	1,800
140	F	2,770	1,385	174	M	3,000	420
142	M	2,100	Two meals	175	M	1,440	600
142	M	2,500	Pt. time service	180	F	2,400	B., R. and L.
145	M	4,000	100	185	F	2,400	1,000
145	F	2,100	Two Rms., bath	192	M	6,000	0
<i>200 to 299 Bed Group</i>							
200	M	\$3,600	B., R. and L.	250	M	\$4,800	\$ 200
200	F	2,310	\$2,310	250	M	6,000	2,400
200	M	3,600	1,000	250	M	3,600	1,000
200	M	6,000	2,000	255	M	10,000	0
200	F	2,500	365	256	M	3,500	2,600
200	F	3,000	600	269	M	5,000	180
200	M	3,360	0	265	M	4,800	1,200
200	M	3,000	Not estimated	267	M	7,500	0
210	M	3,430	1,715	270	M	6,000	2,000
215	F	3,000	900	273	M	5,000	5,000
225	M	5,000	0	275	M	3,600	Maintenance
225	M	7,500	3,000	275	M	5,000	3,000
236	M	9,000	200	285	M	6,000	0
240	M	2,400	Room and bath	291	M	5,000	2,000
250	M	12,000	0	295	M	8,000	2,000
250	M	5,000	Maintenance				



No. of Beds	Sex of Superintendent	Monetary Salary	Monetary Equivalent in Board, Room and Laundry	No. of Beds	Sex of Superintendent	Monetary Salary	Monetary Equivalent in Board, Room and Laundry
<i>300 to 399 Bed Group</i>							
300	M	\$5,000	0	360	M	\$4,000	\$1,000
320	M	4,500	0	360	M	4,500	1,000
350	M	2,700	\$1,500				
<i>400 to 499 Bed Group</i>							
400	M	\$2,400	0	450	M	\$6,500	0
404	M	9,000	\$ 350	471	F	3,000	\$ 484
446	M	8,000	0	476	M	4,200	B., R. and L.
450	M	4,500	1,200	480	M	5,000	0
450	M	7,200	0	485	M	12,000	6,000
450	M	4,800	0	494	M	12,500	0
<i>500 Beds and Over</i>							
500	M	\$5,000	\$3,600	1209	M	\$3,750	\$1,500
500	M	7,500	House only	1202	M	6,500	2,500
625	M	7,500	2,500	1550	M	6,000	1,200
700	M	2,400	1,700	1600	M	6,250	4,000
770	M	5,000	0	1800	M	2,200	Maintenance
850	M	4,500	2,000	1837	M	5,050	0
850	M	4,600	1,800	1900	M	4,000	3,000
900	M	3,600	2,400	2700	M	4,000	Maintenance
1110	M	4,750	2,375				

The convention then took recess until 2 P. M.

## GENERAL SESSION

September 13, 1921, 2:00 P. M.

President Baldwin in the Chair.

THE CHAIR: We will listen now to a paper on the subject of "The Development of Good Professional Work in the Hospital," by Dr. Charles S. Woods, superintendent of Methodist Episcopal Hospital, Indianapolis, Ind.

Every person who is somewhat familiar with hospital activities must be impressed with the fact that the fundamental matter of professional efficiency in the institution has not had the consideration which it unquestionably deserves. There has been no lack of attention to economics in various departments, such as the laundries and kitchens, and it is always easy to get the ear of boards of trustees on the cost of supplies, cost of the care of the patient, expenditures for improvements and receipts. Even the public is pretty well informed on these particular points.

We have been obliged recently to ask ourselves seriously whether or not hospitals were performing the function for which they were brought into existence, and in answering the question I believe that it is true that we have found that many of them were only indifferently satisfying the purpose of their organization.

The hospital can only show that it is worthy of the confidence of the public when it actually enhances the possibility of recovery of the patient. If the home can do as much for the patient as the hospital, then the hospital is failing in its great purpose. If the prevention, diagnosis and cure of diseases are problems of science, clearly the institution must have a scientific program which cannot possibly be carried out in the home. The hospital must have those persons who, and facilities, technique, and spirit which, immensely contribute to the speedy recovery of the patient.

The hospital must be seen as link in the chain of various public health agencies. It is probably the most important factor in the public health program. Within the institution are combined most of the functions of a public health department. The curative procedure may for a moment seem to obscure the preventive efforts. As a matter of fact, however, a part, and it may be true, that the largest part of the service of the hospital to the public is preventive. We who are in daily contact with the professional activities of the hospital know that if more attention were given to the thorough examination of the patients and a study of the various relations of their diseases to probable future trouble, the number of chronic invalids would certainly decrease.

This introduces, then, the idea of professional efficiency in the institution. Let us consider the subject from two points of view. First, the professional organization and work in the institution. Secondly, the visiting physician and surgeon. The admission of patients to the hospital commits the institution at once to the very serious and difficult task of providing those facilities for thorough and expert diagnosis and treatment, and care, which the highest ideals of the most devoted professional men may comprehend. It is fair to say that the institution which does not freely accept such obligation which is imposed upon it by the admission of the patient, is still unworthy of the confidence of the patient, the medical profession, and the public. It is true that the patient himself may not know that the hospital places itself in such relation

to him. The officials of the institution and the board of trustees must recognize the patient's possible ignorance of the hospital's true function, and all the more conscientiously strive to discharge its great duty toward him.

The first step which the institution must take is the equipment of laboratories. Surgeries are laboratories in which the surgeon carries out, according to recognized technique and well established rules, proper surgical procedures. The efficiency of the surgical laboratories is not only very difficult to acquire and maintain, but it is indeed rather inadequately appreciated. The prevention of all surgical accidents in the surgeries is an ideal which ought to be religiously sought. I am convinced that the hospital itself must, in a very large measure at least, assume the leadership and indeed dictatorship in this particular regard. We must be impressed with the inescapable duty which rests upon the hospital to establish and develop such operating room technique, which is the nucleus for the many other things which gather around it, that the patient who is subjected to surgical procedure in the operating room shall always be protected from accidents, ignorance, and negligence on the part of anesthesiologists, assistants, and operating room nurses.

I believe that anesthetics are generally badly administered. There will perhaps remain for many years a difference of opinion as to the choice of an anesthetic, but there certainly cannot be any question about the right of the patient to be anesthetized by a well trained, dependable anesthesiologist. We are certainly impressed with the desirability of unremitting effort to protect the patients from added physical injury by the administration of an anesthetic. I believe that nearly every death that has occurred from the administration of an anesthetic could have been prevented, first, by a careful, painstaking study of the physical condition of the patient; and second, by a well trained anesthesiologist. I mean a person who not only knows how to give an anesthetic, but one who also has the courage to assume the position which is his when he administers the anesthetic. The surgeon is not responsible for the anesthesia. The anesthesiologist himself is responsible, and if an anesthesiologist feels that he cannot assume the hazard which may be involved in a given case, he should have the courage to refuse to give the anesthetic, just as the surgeon has the prerogative to decline to operate when he thinks the risk is not justifiable. Our hospitals should regard the administration of

anesthetics as a matter of the greatest gravity, and one which may ever be susceptible of improvement.

The sterilization of all goods which may conceivably have contact with the field of operation ought to be a thoroughly controlled and carefully watched procedure. There should not be any guesswork about the sterilization, and in order that we may know just what has happened in the sterilizer, bacteriological examinations must be frequent and reliable. No one who has given this subject any attention at all has failed to find an occasional incomplete sterilization so far as bacteriological cultures can determine. If such examinations are not made, there will always be room for uncertainty as to what has happened. The same may be said about the sterile water which is often shown by bacteriological examination not to be sterile. There can be definite knowledge about these particular matters, and it is the hospital's duty, which it cannot relegate or escape, to know the facts.

The technic in the operating room must not be a matter of routine only, but it should be thoroughly well understood by those who participate in it. They should know the reason why certain things are done, and familiar should they be with the principles that any violation of them, however slight, would instantly be detected and be sufficient occasion for retracing steps, or for corrective measures. It is clearly the duty of the surgical supervisor to know the principles of asepsis. I fear operating room supervisors sometimes do their work mechanically and without thorough and refined knowledge of the reasons why certain things are commonly done. Elaborate technic may or may not be employed; efficient technic must be adopted, and there should not be any reasonable excuse for accidents such as infections which may be traced to the supervisors and nurses in the surgeries. I recognize the difficulty in reaching that high degree of operating room technic which practically is unattended by accidents, but we cannot hold ourselves any the less rigidly to such requirements. There must be a keen conscience on the part of every person who is in the organization of these laboratories, and that conscience must be constantly be maintained.

The organization and operation of other laboratories are not less important than the thorough organization and management of the surgical laboratories. I am aware that not every hospital is so located that it can command such well trained laboratory workers as would be required

to make a laboratory of pathology and clinical medicine, and x-ray laboratory, and the pharmacy, those indispensable aids to thorough diagnosis and treatment which institutions that are situated in large cities may employ. Still, there is certainly a vast difference between what may be done and what is actually being accomplished in the smaller hospitals at the present time.

It has been an experience of all of us, perhaps, that physicians and surgeons may fail to use the laboratories and other facilities of the institution, because they seem not to appreciate their service. We know that this is unfair to the patient. It certainly does not improve the quality of professional work in the institution, and if such a course were persisted in by many physicians, those hospitals which are now doing ordinary work would continue to do so, and those hospitals which are attempting to attain higher levels would degenerate.

It has happened that patients have been subjected to abdominal sections, when an examination of the blood would have revealed a typhoid infection. Patients may have been given pretty severe treatment for autointoxication when a blood examination would have shown a high leukocyte count. Many other instances of serious import could be imagined which might be greatly modified by the application of laboratory methods. Is it clear then, that the hospital should recognize that it must not only possess equipment, but it must employ capable persons to do technical work in behalf of the patient. It is not too much to say that this is the prime requisite. All that has been said about the surgical laboratories and the clinical laboratories, may be said with quite as much truth concerning the x-ray, and dietetic laboratories. I think I am safe in saying that if the hospitals can actually become efficient in these particular things, they will then justify their existence.

The institution must provide the nursing. A certain part of the nursing must be professional. Inferentially, a certain other part may be non-professional. I believe that we are far away even today from the determination of the principles of scientific nursing. The institution must be responsible for all kinds of nursing. The patient does not distinguish between that which is professional and technical, and that which is commonplace, and indeed, institutions themselves consider nurses and nursing as everything that relates in any way between the nurses and the patient. Professional nursing is more than care,

it is a part of the professional management of the case. I do not wish to enter upon a discussion of whether nursing is a profession or a mere trade. I insist, however, that since the institution is responsible for nursing, and a certain part of it is technical, and cannot be accomplished by persons who do not have special education and training, then that part of it should be efficient and well done. I conceive the nursing problem in the institution really to be the most difficult one which we have to solve. The selection of supervisors and teachers is a very difficult matter. There are relatively few women who are ambitious to do institutional work, and fewer still who are educated sufficiently well to do it. However, the officials of the school for nurses will determine the quality of work which the students will do, and will fix the character of the school. The school is an educational institution. We have been training young women. We have not been educating them. Let us drop the word "training" and speak only of schools for nurses. The school for nurses has the obligation of preparing the young women who enter it for the practice of the principles of nursing. It is a nice question as to how much academic work shall be required and how much time shall be devoted to practical observation on the floors of the hospital. The hospital is a laboratory in which the student nurse does her work. That school is perhaps best which so combines the daily observations with the class work as to make the student nurse an important factor in the recovery of the patient.

Many hospitals which are doing very good work cannot secure the service of interns or house physicians. It is unnecessary to discuss the reasons why this is true. It is, however, important to say that wherever institutions can induce young medical men to serve in such capacities they should do so, because the professional organization is not complete without resident physicians. From the hospital's point of view, these young men are primarily in the institution to contribute what they may to the restoration of the patient to health, and if they, or any one else, should unfortunately be guided by any other principle, the institution will almost surely fail in the accomplishment of its work. The intern is completing his preparation for the practice of his profession and the institution must give him facilities, and instruction, and opportunities which justify his residence in it. But he is none the less obligated to share with his co-workers in accomplishing the task of healing the sick.



The professional records may be very useful and valuable. There seems to be, however, an indifference to them on the part of some professional men. The institution is probably more responsible for such an attitude than the profession itself. Correct forms on which to make records and fairly satisfactory systems for filing them must be adopted. The requirement that case records should be taken is right. First, the patient has a right to expect such attention from his physician as a case record would require. Secondly, a physician should give his patient such systematic and logical study as a well written case record would require. Thirdly, the public has a right to expect that the institution which receives the sick shall at least vouchsafe a thorough study of diseases, and fourthly, the institution has a right to know for itself that the physician gives his patient so much attention, and that the just requirements of the public are fully met.

The discussion of the part which attending physicians and surgeons assume in a program of medical efficiency in an institution is deferred to the end of this paper because it is by far the most important.

First, there is a mutual obligation resting upon the attending physicians and surgeons and the officials of the hospital.

Second, every professional man who comes to the institution to do work become pro tempore a part of the organization. He therefore, places himself voluntarily under the responsibility of knowing and maintaining the standards of the institution.

Third, he is making his share of the history of the institution and helping to build its tradition, and what he is, is reflected by the institution itself. It becomes apparent at once that the physician is largely forming the character of the institution, and he is himself being influenced by the institution and its standards. If he merely regards the institution as a place to which to take his patient, and if the institution is not worthy of higher respect on his part, then of course, he does not wish to become a part of such an organization. But if the institution is really efficient in the professional things, then he does himself discredit when he takes the view that the hospital is but a place wherein to house the sick. The institution cannot become professionally efficient without the devoted cooperation of all those professional people who work in it, and the physician himself can

positively do more toward the improvement of the professional work in the institution than anyone else. By his constructive criticism, his willingness to join with his co-workers in elevating standards, his insistence upon the most faithful observance of scientific principles and the rigid application of them to his work, he becomes after all, the teacher and the example for all of us. His use of the laboratories to aid him in diagnosis and treatment, his enthusiastic support of those efforts which look toward the elimination of unscientific and undesirable features, his willingness to adopt new methods and to use them, all contribute to the better nursing and treatment of his patients.

It does not seem to me that there can be any argument about the prerogative and duty of the institution to exclude from the use of its facilities, and the employment of its professional personnel, those men who do not respect the exalted ideals of the finest medical work. Here and there we find an effort to destroy the purpose of organizations of medical men in institutions, and to wipe out the authority of the institution in the determination of the quality of professional service. I think that we should boldly meet all such attempts with the facts. We should go straight to the best men and women of our communities with a program of medical efficiency; we should try to lead the public to see that there is such a thing, and that it is altogether desirable. Professional efficiency in the institution can in no way interfere with the ambitions of good men. If it should block the schemes of unworthy medical men, we should be rather grateful.

THE CHAIR: Dr. Woods' paper is open for discussion. It is a paper that is worthy of discussion.

DR. HUDSON TALBOTT: While the others are gathering their thoughts, and in order that this most excellent paper may not go without discussion, I rise to express my great appreciation of the splendid paper of Dr. Woods, as I believe that there is no subject more vital to the progress of our hospital today than the subject discussed by Dr. Woods. It is most important that our hospitals throughout the land create a more efficient standard than has been known. Great progress has been made in the last year or two. The hospital with which I have the honor of being associated has found it necessary to eliminate from its visiting staff some very splendid men, but men who were unwilling to cooperate with the hospital in introducing the higher standards of professional work.

It was a loss; that institution needed the funds that were being brought in by some of those men, splendid fellows in a way, bringing large patronage, but they had to be asked to go elsewhere when sometimes our beds were empty and our purse was low. But that institution has not suffered by the expulsion of those doctors. When the better class of men found that the fellows who were doing questionable service or work that was not as skillful as it ought to be were being eliminated, the better men were ready to come and fill the beds. If you fear that the demanding of your men to do better work will result in a loss to your institution, you are mistaken.

THE CHAIR: Is there any further discussion?

DR. DUEMLING, of Fort Wayne: I would not like to see this paper of Dr. Woods' go without discussion, and I only waited for someone to get up and break the ice. The doctor has made a number of excellent points. The first one that struck me very forcibly was what he had to say in regard to the giving of anesthetics. I would like to add this observation, that while the death occurring in the operating room from anesthetic is a very spectacular thing and fastens itself on our memory, yet that is the very least of the trouble. The reason has been given by Dr. Woods; the patient is brought to the operating room with no preparation. Of course there are cases of emergency where they could not have had preparation, but too often there is no urinalysis. Why? Well, many times the physician is an important person, and what he says goes, and as has been pointed out by another speaker, the hospital authorities who know better are actually afraid to call attention to this dereliction because of the influence this man wields. The best way is systematic history taking of every patient who enters that hospital, the insistence by the hospital authorities upon a diagnosis to be made, tentatively at least, and that a real history be taken before that patient is subjected to any surgical or any other kind of treatment. There can be no doubt that proper and painstaking history taking will prevent typhoid fever patients from being operated on for appendicitis, will prevent a patient from being run to the operating room with no preparation and no examination of the blood.

DR. HUDSON TALBOTT: Our hospital some time ago issued this order: that every organ removed on the operating table must go to our pathologist, and if we find

any operator sending normal organs down there for several consecutive times, he must tell us why.

THE CHAIR: While I realize the importance of Dr. Woods' paper, the hour makes it imperative that we proceed with the program, and unless there is objection, we will close the discussion and proceed with the paper on "Food Preservation," by Mr. W. P. Heath, of Chicago, Ill.

MR. HEATH: When my place upon your program was arranged, I had no idea that American hospitals were constantly taking care of nearly a million people.

I became doubly impressed at the opportunity to tell you the story of "The New Sanitation for Dairy Products" because no body of men has greater influence in properly directing along safe channels the public's ideas about food. Eight per cent of our population become your charges each year, and these millions of people leave hospitals to spread broadcast their newly acquired knowledge of correct eating habits, and wiser selection of food.

All food intended for human consumption should be clean. However, we need to be especially vigilant about dairy products. Dr. Munger tells us in the August "Modern Hospital" of his interesting experience with small epidemics arising in hospitals from the use of pasteurized milk. The difficulties were overcome by changing to certified milk, but we cannot but be impressed with the extreme care needed to properly safeguard the certified milk after it reaches the hospital.

The very nature of dairy products makes them especially susceptible to contamination. Butter becomes tainted in the ice box with fish or onions. If you smoke a cigar where butter is being churned you injure its delicacy of aroma and perfection of flavor. One very successful creamery in Wisconsin had to close a branch plant because all the butter made there became tainted with the sulphate fumes emanating from the local pulp mill. Cold storage men tell us they have to be more particular in the storage of butter than anything else, because of its affinity for contaminating odors.

The quarter pound package of butter became popular because butter spoils so quickly. Bacteria develop, decomposition sets in, and the butter becomes rancid in a very short time.

What is the cause?

Air! *Just common, ordinary air!* The air we breathe! The air which a wise Nature intended for the human lungs, but never to be incorporated into foods. In making butter you fill a churn half full of cream, then shut the doors tight, and splash the cream around in air for three-quarters of an hour until the butter gathers. When it has gathered we find ten per cent of the volume of the butter consists of microscopic bubbles of air. Every year this ten per cent of air in butter caused so many millions of dollars annual loss that its elimination became one of our serious economic problems.

Our Department of Agriculture conducted exhaustive research work upon this ten per cent of air in butter. In 1916 it issued a bulletin setting forth that "off flavors" in butter were caused directly by oxidation due to the imprisoned air bubbles.

Several years later the Department of Agriculture sent its butter expert, L. A. Rogers, to address the Minnesota Buttermakers' Convention; and he told them that air was the deteriorating factor in butter; that they could add to their quality by so manipulating the butter in the churn that the least possible amount of air be incorporated.

In addition to food deterioration, there is still another most important and vital food loss, chargeable to oxidative processes. Dr. Hess points out that the degree to which dairy products will retain their vitamins is proportional to the degree of protection from oxidative processes given to the dairy products in handling. In other words, exposure to air destroys vitamins.

However, it is chiefly for sanitary reasons that we should exclude air from butter. To prevent decomposition, and to retain vitamins through air exclusion are both to be desired. I don't purpose to minimize their importance, but rather to point out that air infects the butter during churning, and subsequently fosters bacterial development; and that it is these combined evils that make major in character our sanitary and bacteriological objections to air.

The ignorant buttermaker, while admitting that his wife knows enough to keep air from getting into her sealed fruit jars, still will stoutly maintain that the air in butter does not materially infect it. But the scientist doesn't deduce conclusions from followers of "rule of thumb" method. He consults authorities. America has an authority upon atmospheric dust second to none in the

world. He is Dr. Jacques W. Redway of the Meteorological Laboratory at Mount Vernon, N. Y. His work has been so thorough and conclusive in character that I am going to quote from his bulletin upon the dust problem prepared for the Department of the Interior, Bureau of Education. He says:

"In thickly peopled communities the flying dust at the earth's surface is a menace to health that must be ranked with noxious insects and contaminated water. Dried sputum is a constituent of the street dust of cities, and cases of infection by means of it have been established beyond reasonable doubt. As a matter of fact, tubercle bacilli are rarely absent from street dust, and in city streets they are generally the most notable feature of germ life. The colon bacillus is almost always in evidence in street dust. It is the product of the horse dung content of such dust. Here is the result of daily collections covering a period of several years:

*"Vegetable matter.* Horse dung, garbage, leaf dust in season, foliage smut, and pollen in season.

*"Animal matter.* The egg of insects, fragments of insect anatomy and scales of moths, and offal.

*"Biological matter.* Bacteria and micrococci of various kinds, mainly when the humidity is above ninety per cent, the spores and filaments of molds, and myxobacteria from excrementitious matter."

And again, in the "Medical Times," he writes:

"Clean air—which mortals never breathe—rarely contains fewer than three thousand visible dust particles per cubic inch of air. In general, the air ordinarily in public buildings contains from twenty thousand to forty thousand dust particles per cubic inch."

Thus even clean air in a half ounce patty of butter introduces 261 dust particles of questionable matter.

This scientist is merely giving us exact scientific knowledge of the dust we see with the naked eye when an automobile searchlight sends a beam diagonally across our line of vision, or when a beam of sunlight creeps into a darkened room. These particles are so dangerous in character that we have statutes forbidding the exposure of foods.

For example, the New York Sanitary Code reads:

"No food intended for human consumption should be kept, sold, offered for sale, or transported unless protected from dust, dirt, flies and other contaminations."



Permitting dust to settle on the outside of a protecting skin of an apple is filthy, dangerous and contrary to law. Yet it is lawful to introduce this same filth into butter, a food that appears on the American table three times a day.

Nature herself protects her fruits with a peel to keep air infection and oxidation from destroying them. And we recognize her beneficent measures of protection and supplement them with statutes.

Hessler further condemns air in these words: "The air of cities is so full of bacteria and fungoid forms of life that produce decomposition that a few hours' exposure to the air in warm weather is sufficient to spoil food."

Hausner confirms this when he says: "All ferments probably require contact with free oxygen in order to develop. Hence, if we keep food absolutely guarded from all access of air, it will not go bad. The presence of free oxygen is conducive to putrefaction in spite of any previous heating.

Why further multiply the evidence? The fact is that America's billion pounds of butter each year has been infected, unclean, laden with bacteria, and of diminishing keeping quality and vitamine content, and air has been the mischief maker.

It has been well known that this air pollution would have to continue indefinitely until some scientist should work out a practical solution. Early investigators therefore sought to make butter air-free. The earliest method employed was to melt the butter and pour the melted butter into paraffined wooden tubs. This of course was no solution, because the melting destroyed the character of the butter. Vacuum churning presented a possible solution and early investigators, notably Bouska, sought to stop butter deterioration losses and infection by vacuum means. It was condemned as impractical.

I was satisfied the problem had to be attacked from a new angle and conceived the idea of replacing the infected bubbles of air with pure, dustless bubbles of a non-oxidizing atmosphere instead. It was clear at the beginning that the atmosphere selected to replace air had to be perfect from eight standpoints: (1) purity, (2) wholesomeness, (3) freedom from dust, (4) flavor desirability, (5) absence of free oxygen, (6) vitamine preservation, (7) bacteria destruction, (8) specific gravity.

From the large number of gases considered, only one measured up to the requirements—carbon dioxide. Car-

bon dioxide is Nature's selection. Nature builds all food from carbon dioxide, moisture, and mineral salts under the influence of direct sunlight upon chlorophyll in the plant leaf. Nature decreed that yeast should put pure bubbles of carbon dioxide in the rising bread to make it porous and palatable, and Nature made this same carbon dioxide lend its charm to beverages down through the ages, improving flavor, inhibiting bacteria development, and preventing deterioration.

Dr. W. W. Skinner, of the Bureau of Chemistry, United States Department of Agriculture, asserts that carbon dioxide is a wholesome product, identical with the carbon dioxide which occurs naturally in mineral springs in the United States, springs which are so highly esteemed for their effervescent properties.

This of course followed numerous analyses of the commercial carbon dioxide bought in drums under pressure, whereby it was shown to be free from dust and with not more than one part in ten thousand of free oxygen. All carbon dioxide is of clean flavor, else it could not be used for beverage purposes. It is over fifty per cent heavier than air, making it admirable from a specific gravity standpoint for the replacement process. Thus six of our eight requirements were immediately satisfied.

Would it suffocate bacteria and save vitamins? If so, here we had an ideal atmosphere. Both of these questions were answered in the affirmative by the Franks process of putting up fresh fruit. In this process the air is exhausted from fresh picked fruit by means of a vacuum and replaced with carbon dioxide. The food is subsequently sealed in this pure atmosphere. Many foods were kept for years in this way, among them orange juice, which is very rich in vitamins. Healthy pigeons were infected with scrofula and neuritis and when near death were fed with orange juice. The juice had been preserved for eight months by the Franks process. The pigeons revived and the experiment proved that in foods preserved by this process the vitamins are not destroyed.

The most exhaustive experimentation clearly showed that these foods in which carbon dioxide replaced the air were also free from bacteria, thus proving that most bacteria need warmth, moisture and oxygen if they are to propagate. With this unchallenged foundation that carbon dioxide measured up to the eight requirements described above, the properties of carbonated butter could be foretold even before it was made, just as Mendeleef

foretold the properties of elements missing from his periodic chart even before these missing elements were discovered.

Having found the ideal atmosphere, I started to experiment. I filled two churns from the same vat of cream and started them churning simultaneously. The cream in one was infected as usual by splashing for forty-five minutes in air.

I forced the air out of the other churn by admitting carbon dioxide under pressure at the bottom of the churn. The carbon dioxide bubbling up through the cream forced the lighter air out of the small open vent at the top of churn. When the invigorating odor of carbon dioxide was apparent at the vent, it was conclusive proof that the air had been all expelled. The vent was then closed, and carbonic pressure allowed to generate in the churn to one and one-half pounds pressure to the square inch.

The supply of carbon dioxide was then shut off and the churn revolved for three minutes. Upon opening the air vent there was inward suction, proving that so much carbon dioxide had been dissolved in the cream that a partial vacuum had been created. The vacuum was broken by admitting more carbon dioxide, and churning was continued for forty minutes.

The carbonated butter had a much better flavor than the air-churned product, because the good flavor of the cream had been intensified. Subsequent experiments with bad flavored cream showed that carbonation also intensified bad flavors; furthermore, that if cream passed through unsanitary pipes, the taint would be magnified by carbon dioxide.

I was not surprised at this result, because carbonated water intensifies the flavor of fountain drinks. Clearly, carbon dioxide was an acid test of quality, only creameries receiving good cream being able to use it.

Bacteriological reports showed amazing reductions, decreasing the bacteria from 1,400,000, air-churned, to 7,650, carbonated. To compare the relative value of pasteurization and carbonation in buttermaking, one-half a vat of cream was made into carbonated butter without pasteurization. The other half was pasteurized and churned in air. Samples were run in triplicate in the laboratories of the American Creamery Buttermakers' Association as follows:

Unpasteurized	Carbonated	Pasteurized	Uncarbonated
	340,000		640,000
	260,000		700,000
	290,000		840,000
Average	296,000	Average	727,000

Thus there was 145 per cent more bacteria in ordinary pasteurized butter than in unpasteurized carbonated butter made from the same cream.

By getting rid of infection, free oxygen, and bacteria, carbonated butter develops remarkable keeping quality. One shipment was lost two months and finally showed up in the possession of another railroad. The distributor thought it must surely be spoiled, but found it as fresh and sweet as though just taken from the churn.

Ever since the Ancients first made butter by shaking milk in skin bags suspended from trees, it has been infected with air. It is one of the misfortunes of the ages that billions of dollars' worth of this valuable food should have been an unclean, rapidly spoiling product thru ignorance in manufacturing methods.

With ten per cent of air destructive in butter, what shall we say of ice cream which contains fifty per cent of air? Five times as much air, and we consume larger portions!!! Where the cleanest air introduces 261 dust particles in a half ounce patty of butter, the average dish of ice cream contains 10,500 dust particles even when made in clean air which "mortals never breathe" as Doctor Redway expresses it.

Because ice cream is the favorite food of little children, we cannot be too particular about making it safe. A brick of ice cream sees eleven manufacturing steps before it goes to the dealer. Beating fifty per cent of air into it is one of these steps, and we cannot, without challenging our intelligence, call it anything but a process of infection.

Manufacturers don't like to use gelatine in ice cream. Yet they use it to make ice cream stand up in shipment. Freezing ice cream in carbon dioxide enables the manufacturer to use less gelatine because the bubbles, having greater weight, give greater stability to the product.

In ice cream also we have a reduced bacteria count, and like the manufacture of carbonated butter, it is essential that only the purest and best ingredients be used and rigid sanitation enforced, else any taint will be intensified by the carbon dioxide.

The ice cream industry frequently comes into ill repute because of conditions over which, in the past, the manu-

facturer has had no control. A single case of olive poisoning is played up in big headline, because unusual, yet the following startling epidemic gets only an inch.

"Springfield, Ill., July 31, Chocolate ice cream eaten at a church social, near Fountain Green in the Eastern part of Hancock County, has caused an extensive epidemic of para-typhoid fever, it was announced at the state department of public health this morning. More than 100 persons are seriously ill."

Carbonation is the method employed by two hundred manufacturers in the United States and Canada. Yet, though the process has been used two years there has never been a single sickness from carbonated dairy products.

Modern science and invention are combining to make epidemics increasingly rare. The dairy industry is in the hands of intelligent men. Every ice cream manufacturer wants to surround his product with every possible safeguard.

The adoption everywhere of carbonation is a mark of distinction of which the dairy industry may well be proud, when you consider that man by nature is steeped in inertia and petrified in tradition, thus making innovations move slowly.

Air has been in butter for scores of centuries. However, past practice does not excuse air infection of dairy products any more than the age old custom of drinking unpasteurized milk would excuse the unrestricted practice today.

The use of carbon dioxide in protecting butter and ice cream is merely the forerunner of bigger accomplishments to come in the handling of milk. The instant milk leaves the cow's udder it becomes infected. The force of the milk stream whips air into the partially filled pails. Because carbon dioxide is fifty-three per cent heavier than air, it is practical, economical, and certainly expedient that the milk stream travel through a carbonic atmosphere into a specially constructed pail previously filled with carbon dioxide. Transfer can be made to a ten gallon can filled full of carbon dioxide, which pours with the milk from pail to can.

A fifty pound drum of carbon dioxide would protect from air two thousand gallons of the farmers' milk, at a cost of seven mills per gallon.

The distributor could protect milk surfaces and tubular coolers with carbonic atmosphere even to the point of

admitting milk to bottles automatically filled with carbon dioxide before they are fed to filling machines. By carbon dioxide recovery the distributors' cost would be less than three mills per gallon. The total cost of protecting a quart of milk from air infection and vitamine destruction through oxidation would therefore be less than a quarter of a cent per quart.

The tremendous reduction of bacteria by agitating cream in a churn under carbonic pressure convinced me that the application of pressure is destined to replace pasteurization of milk, thus retaining full vitamine content, and making unnecessary the precipitation by heat of albuminoids and ash constituents.

I believe the above method upon which I am working is destined to be the solution of safer and better milk.

No body of men can better appreciate the possibility of this achievement than you men whose minds have followed seemingly more impossible propositions in biology pass from Hypothesis to Theory and Law.

In sanitation you are the advance guard of progress. Enlightened public health conscience follows in the wake of hospital practice. Hospitals early recognized the greater sanitation of dust protected packages of foods. Hospitals first abandoned the roller towel and common drinking cup. Your charges are more than patients. They are students of sanitation, quick to learn from you of those things that make for better living and longer life.

And because of this fact I am happy to commend to your thoughtful consideration this new message of health and sanitation.



## ROUND TABLE CONFERENCE

"What Constitutes Good Service to the Patient?"

September 13, 1921—3 p. m.

Dr. M. T. MacEachern, Chairman

CHAIRMAN MACEACHERN: Ladies and Gentlemen: You have on your chairs copies of certain questions which shall constitute the agenda for this round table conference.

This subject was at first intended to be treated in a paper, but in communication with our worthy President it was changed, at his suggestion, to a round table conference. I am going to speak for twenty or twenty-five minutes by way of introducing this subject and I hope you will all be ready to discuss it energetically for the following half hour at least and ask all the questions you can.

The acid test of the right of hospitals and their organizations to exist is the rendering of good service to the patient.

This service must accomplish certain definite objectives in regard to the patient being treated and these are:

*Firstly*—The giving of the patient a good reception on admission, so as to make a pleasing impression and to establish in the patient a smooth and comfortable mental attitude towards the hospital.

*Secondly*—The prompt attention at all times to the patient in all matters—large or small, particularly the latter.

*Thirdly*—The routine and competent examination of the patient with careful record of everything about the patient while in the hospital.

*Fourthly*—The availability and utilizing of all the diagnostic and special treatment facilities necessary in making of an accurate diagnosis and supplying treatment effectively.

*Fifthly*—The affording of consultations as necessary.

*Sixthly*—The analysis of results—by staff review.

*Seventhly*—The monthly report to the board of trustees.

The service in the hospital must aim at making an early and competent diagnosis, the applying of effectual treatment, and finally, the returning of the patient to health and producing capacity in the shortest time possible and

in the most comfortable manner. That is what the patient expects, and what the public who are supporting the hospital consider they pay their money for, and, in fact, that is your written or implied agreement with your patient. To do this the patient must be the recipient of several services while in the hospital, and such services as will most effectively meet the conditions. These services are of two classes, mainly—

(a) Personal or social.

(b) Scientific—diagnostic, care and treatment.

## Part I

### Personal or Social Service

The best publicity your hospital can secure is a satisfied patient going home well, and all services rendered in the hospital should aim at establishing such a feeling in the patient's mind towards the hospital. Your institution must so appeal to the public and the community that there will be a confidence established—that the people will feel the hospital is the only place where they can improve and get well. There must also be developed a professional confidence in the hospital. It is very important to have these three confidences: the patient, the doctor and the community.

In outlining the various services I have put down the first as personal or social. I do not know whether these are the best terms to use, but I mean the general welfare of the patient. We must aim to establish in our patient a contented mental attitude as quickly as possible, and your hospital should have such a receptive atmosphere about it that the mental equilibrium of the patient is retained as near as possible to normal when the transfer from home to hospital is made. I cannot emphasize this important moment too strongly to you all. The kindly, sympathetic, interested receptive admission of the patient goes a long way to establish an initial confidence and mental comfort on the part of the patient towards the hospital. This implies a quiet and attractive admitting room and personality, the latter being secured best by the selection of the proper type of nurse, because the white uniform appeals, especially when clothing a personality characterized by the qualifications I have outlined. Administrators must remember you are always dealing with abnormal human nature, at that particular time an occasion of great mental anxiety for patient and rela-

tives or friends, a time when people are very much harder to handle. Hospital administrators must specialize in meeting this and turning the irritable mental attitudes into happiness and confidence.

The second group of impressions the patient secures is when he arrives at the ward. The way he is received and cared for here is of vital importance. The initial attention cannot be too strongly emphasized and assistance to get undressed and comfortable in bed, instead of: "Yes, this is your bed; go to bed." I have seen patients wait far too long, sitting on a hard chair, and having to struggle into bed themselves. This is not hospital attention at all. The placing of the patient in the ward is a vital matter. If he is placed near a very sick patient, an anesthetic case, an undesirable of any type, then follows a protest and discontent. In large open wards this should be strictly guarded against.

While a patient in the ward personal attention should be rendered as well as scientific. Anticipation of the patient's wants, attention to the little things, the little comforts, promptness in service, all mean much. If a poor and needy case, the social service can step in and do much to carry the burdens of worry for the patient. The furnishing of papers, books, magazines and various forms of entertainment must not be overlooked. All the attention should impress the patient with the fact that the hospital authorities knew he or she was there and all interested in his or her condition. Treat the patients as your guests, not in a machine-like or routine manner.

A time when personal attention is needed is during the hours of anxiety over the seriously ill. If friendless, the hospital must step in and take the part of the family, and here is needed deepest sympathy and human interest and kindness, always remembering if this was one of your own family. Here the kind sympathy and big heart is needed. If anxious members of the family are present, or relatives or friends, a kindly, sympathetic treatment of them is necessary. Let us never abstract the human element out of our work; let us constantly reach out to assist our patients physically, mentally and morally, if necessary. In the latter connection, cooperation with the minister or the priest should be expected in all hospitals.

Therefore, let us so direct our efforts, other than the scientific to be hereinafter discussed, in such a manner that we inspire the confidence of our patient, establish a mental attitude of comfort, making our patient feel and

realize we have a constructive interest in his or her welfare, and so attend our duties of this class that the patient carries away kind thoughts and memories.

## Part II

The scientific services of the hospital may be considered from two phases:

*Firstly*—Diagnosis.

*Secondly*—Care and treatment.

In regard to the former or in the making of a diagnosis, certain obligations must be fulfilled by the doctor to the patient. He must make a competent diagnosis in the very quickest time possible. You will admit this is absolutely essential in order that immediate and correct treatment be commenced. Diagnosis of disease and conditions is frequently a complicated procedure and cannot always be done by the mere powers and faculties of the doctor, no matter how competent he is. He must be assisted in this, and that is frequently why he sends his patient to the hospital. He wants to have the assistance of the hospital facilities in making or in confirming his diagnosis. The hospital must provide such auxiliary facilities and this is one way in which it differs from a hotel or boarding house. It must offer certain scientific methods in diagnosis. The facilities available vary in different hospitals and particularly according to the size of the institution. However, there is a fundamental or minimum service they all should supply, regardless of size. This fundamental or minimum service may be elaborated as the hospital increases in size till a maximum service is reached. I cannot conceive of any hospital existing and caring for the sick which cannot provide the following minimum facilities to help the doctor make a good diagnosis:

### 1. *X-ray.*

It seems almost impossible to conceive of any hospital without an accessible x-ray service, whether in the hospital or just nearby. If done in the doctor's office by his private machine, the reports can be sent into the hospital to become part of the record on permanent file. It is not essential, of course, that all the intricate and complex x-ray work should be done in every plant. It is readily possible to send patients a distance for certain examinations, and I particularly refer to the deeper work, such as examination of the stomach and intestines as now developed today. Gastro-intestinal work can be sent to the

more highly developed departments elsewhere. The market supplies small outfits, such as the bedside type, with intensifying screens which do almost any work and are reasonable in price. The great importance of this service makes it essential that every hospital should make some arrangements to supply it.

## 2. *Laboratories.*

By laboratories we mean in this paper the clinical laboratory with all its branches—pathology, bacteriology, serology, blood chemistry, etc. The laboratory may be developed from a basic or fundamental minimum service to a highly complex or maximum service. Laboratory service is extremely essential in every hospital. In order to save our time at this round table conference I am going to leave with you this reprint: "Laboratory Service in Hospitals of Less Than One Hundred Beds," which sets forth concisely and practically the fundamental laboratory service which should be given by all hospitals, that service which is absolutely necessary to have available for making a diagnosis. The larger the hospital the more highly developed the service must be and should be available to all patients. It is impossible for all hospitals to carry a complete maximum laboratory service, but there should be such a cooperation between the small and large laboratories that all should benefit by an available efficient service. The fully developed divisional laboratory today has several branches, as: Pathology, bacteriology, serology, clinical microscopy, blood chemistry, etc. These are very important and play an important role in the diagnosis of disease. The development of such services demand more costly and elaborate equipment and competent personnel. The growth of the hospital from two hundred and fifty beds on means more highly developed laboratories that cannot be carried by the smaller hospitals and which would not be used sufficiently to warrant worth while. It is a well-known fact today that the recent development of blood chemistry in relation to disease has established and developed metabolism laboratories all over, and it is also necessary that this service be available to patients with diabetes, nephritis and such diseases. Basal metabolism tests and their relation to goitre cannot be overestimated. Laboratory service must embrace all.

## 3. *The Electro-Cardiograph.*

Several large hospitals today have heart departments where, by means of the electro-cardiograph, a more ac-

curate and detailed diagnosis can be made. This apparatus is costly and requires special skill to operate it and as a consequence are not found generally. Authorities are also somewhat at variance yet as to the real value of this department. Personally, I believe it is a most valuable adjunct in hospital service, because it involves the service of a good man on heart conditions, and as the routine carries with it a complete examination, involving particularly a history, a urinalysis, blood pressure, x-ray and fluoroscope. The cardiogram, no doubt, gives a finer diagnosis of how the heart muscle is acting than we could secure through physical examination alone.

#### 4. *Physiotherapy Department.*

This department is used mainly for treatment, but in one respect at least it is used for diagnosis and prognosis. I refer particularly to its use in muscle and nerve testing and reaction. Of course, any hospital could and should have faradism and galvanism for this work, but in the larger hospitals with their better and more complicated equipment a more extensive and efficient service can be offered.

#### 5. *Consultation.*

The importance of consultation can hardly be emphasized too strongly. Patients suffering with conditions of a serious nature or out of the ordinary should have the advantage of more opinions than one. There should always be a staff available for such work and the hospital should encourage it all they could. It is pleasing to note that several hospitals I could mention do not allow any abdomen to be opened without consultation first.

6. *Other diagnostic means* of a minor nature are found in hospitals today and these would embrace numerous small diagnostic instruments which all hospitals can have.

Finally, the object to aim at is an early competent diagnosis evolved by physical examination and, if necessary, the laboratory services and consultation. We must realize that if the diagnosis is wrong the treatment will likely be wrong and, of necessity, the results obtained. Hence, every hospital must provide such facilities as indicated to assist the doctor in making or confirming his diagnosis.

In the consideration of the second phase of this question there are several points to be noted in regard to the care and treatment of patients. Taking for granted that the doctor is competent to lay down or outline the best treatment applicable to the case in question, then the carrying out of such orders to the letter and efficiently



throws the responsibility, in a great measure, on the hospital through its staff of nurses, internes, orderlies and others. The hospital is responsible for a good service to the patient through its staff. Certain services may be considered separately.

(a) *The Nursing Service.*

I cannot attach too much importance to this, and in my hospital administration I always feel that the nursing service has much to do with the success or otherwise of my administration. What, then, do we need? Let me enumerate a few essentials:

1. Well-trained nurses, especially in practical procedure, so as to do same with the maximum comfort and efficiency to the patient.

2. Ethical, dignified persons with a personality that inspires and soothes the patient; gentleness, kindness, tact, optimism and foresight—one who can anticipate wants and sidetrack complaints or disagreeableness.

3. Diligent and prompt attention to the little things the patient wants.

4. Desire to please and do everything possible to assist the patient back to health. To accomplish this, good leadership is necessary and the instilling into the nurse's mind her duty and obligation to the hospital and patient. In my hospital I have the following paragraph on each petticoat cover sheet of chart so that it is constantly being read by the nurses and others. It reads thus:

"The best publicity a hospital can secure and the most important factor in its success as an institution is to send all its patients home well pleased with the treatment they have received when ill. The hospital with its equipment and personnel is to assist the doctor in every possible way to bring the patient back to health in the quickest and most comfortable manner, and thus develop in the patient an appreciation of such service. To accomplish this there must be a close personal touch developed between staff and patient. This can be obtained by a keen appreciation and anticipation of what the patient needs and prompt attention to all these, whether large or small. At all times the question uppermost in the minds of those who serve should be: 'Are all my patients satisfied?' After all, the service we can render our patients is the acid test of how we are discharging our duties and responsibilities falling on us in this work."

5. Nurses should be trained carefully in making accurate observation on the patient and expressing same intelligently on the chart. The nurse is the doctor's third eye, and an important eye; inasmuch as the patient is under her observation constantly during the twenty-four

hours, whereas only casually, so far as the doctor is concerned. He depends on the report found on the chart, which should be the intelligent expression of her minute-to-minute, moment-to-moment observations.

(b) *The Interne Service.*

You may or may not have an interne service in your hospital. If you have, the internes must realize that they are there to serve the patient under the directions of the doctor and the hospital, that they are working for the hospital and in return for their labor secure valuable experience. The hospital and the attending doctors are obligated to show an interest in the interne and do all that is possible to train him scientifically and ethically. He should approach and attend the patient with tact and diligence and so conduct himself as to inspire a confidence, which is so essential for his own success also. The interne service is a most valuable adjunct and advantage to the hospital—not alone for the value in attending to all emergencies, but in the more intensely and effectually carrying on all the medical services of the institution, and here I might specially mention the assistance they are in the work of medical records. In the closed hospitals today we find one interne to about thirty patients, whereas in the open hospital one interne to fifty patients seems to be the ratio.

(c) *The Orderly or Attendant Service.*

Here again is an extremely important factor in hospital service, especially as it applies to the male patients. An orderly service in a hospital must be organized. Primarily, there should be a head orderly who has good judgment in selecting his men and who is able to teach them. They must know how to do well such treatment procedures as cannot be done by a nurse or interne. They should be particular about their appearance and should also be diligent and prompt in their service to the patient. I find that the grading of orderlies in a large hospital where there are fifty or sixty has been a great advantage. Before accepting service they should be given the fundamental instruction and do their work under individual supervision till fairly competent. They then take the orderly's course, and if they pass the examination at the end of that time they can go on for an attendant's course, which covers a period of six months, at the end of which time an examination is set. If successful their wages are raised to the higher grade. This

has been a splendid system with us, and we have now a training school for orderlies and attendants, which has meant a better grade of men, staying longer at their work and giving better service in every respect. In fact, I can truthfully say that in one whole year I have only had two complaints in our orderly service, and these were very minor in nature.

(d) *Food Service.*

This is extremely important in every hospital and implies two or three fundamentals:

*First*—The food must be of a good quality, and this rests with your buyer.

*Second*—The food must be well prepared, and this rests with the dietitian or one in charge of the kitchen.

*Third*—The food must be properly served; this means it must be hot and daintily arranged. This is the head nurse's responsibility.

So far as possible, a selective service should be carried out. Today many hospitals have menus for their private wards.

Therefore, in food service regard quality, preparation and service as the three fundamentals in keeping your patient satisfied and pleased.

(e) *Pharmacy Service.*

The most important point in connection with this is the ready facility with which medicines can be secured after being ordered. I am assuming that every hospital has a pharmacy service or at least one nearby. This service will be materially facilitated for the pharmacist if the prescriptions are properly and plainly filled out with name in full, date and doctor's name. The adherence to stock prescriptions according to the hospital pharmacopæia is a splendid plan for economy, efficiency and service.

(f) *Laundry and Linen.*

Most hospitals have trouble with this service. There must be a sufficient supply of clean and fresh linen at all times for patients. Several methods have been tried, but I believe the tendency today to have a well organized central linen room in charge of a reliable person is most satisfactory. There must be a sufficient supply of linen in circulation and good laundry facilities. Patients should not be kept waiting for linen to make up their beds. It is extremely important for babies and infants especially, to have sufficient clean and wholesome linen always.

*(g) Operating Room Service.*

This presupposes a well-organized and competent department with trained personnel. I believe all operations should be supervised by a graduate nurse of experience. It is impossible for me to go into the details of this department excepting to say that it should have all the ordinary and special equipment necessary to do the work, and especially such emergency appliances and facilities as are necessary. There is one particular phase which it is necessary to develop for efficiency and that is the establishment of routine pathological service in connection with the operating rooms. Every hospital should routinely put all their specimens through and have a report thereof recorded on the patient's file, together with the operating room report. This will mean greatly increased efficiency in the professional work of the hospital.

*(h) Anesthetic Service.*

Anesthetics should always be handled by competent and experienced anesthetists. Patients for operation, other than emergency, should be in the hospital at least twelve to eighteen hours prior to the operation, so as to be thoroughly examined, such examination including urinalysis, chest, heart, etc., especially the blood pressure. Throat, nose and vaginal smears in females should be made in all infants and children. This means extra work for the hospital, but is worth while. The preparation of all patients for operation is an important factor and in this oral cleansing should not be overlooked. A general examination of patient will detect any other conditions that might be present or developing.

*(i) Physiotherapy Service.*

This includes massage, electrotherapy, hydrotherapy and mechanotherapy. It should be carried on under the management of a competent medical man specialized in this work. As a general rule, there should be one treatment officer for every fourteen patients. The department is a great adjunct in the treatment of many conditions, medical and surgical. The intelligent use of this department reduces the patient's days' stay much in the hospital.

*(j) Other Services.*

Every hospital should have facilities close at hand for the hasty reception and treatment of accident cases, so that immediate first aids can be rendered without waiting for formalities. This means an accident room or ward

with an operating room or dressing room close at hand. The room should be ready, always set up, and a doctor, nurse and orderly available. Life saving devices should be readily available and such equipment or antidotes as needed in cases of poisoning.

The admission of patients must be prompt and courteous.

The social service department should be ever functioning and ready at hand to help the needy, the distressed and troubled, by assuming their worries and anxieties.

The business department of the hospital should conduct their part of the work in such a manner as will not antagonize the patient or friends. Business negotiations must not be carried on with patients when ill, and always, as far as possible, these matters taken up with others who might assume the responsibility rather than the patient.

### PART III

#### CONCLUSION

The question arises in your minds: How do we know that we are getting good service in the hospital? In order to answer this we must have a good working organization with competent heads of departments and staff who assume responsibility for service and who are under constant review by the officials.

The medical staff review conference of the scientific work of the hospital each month will at least reveal some knowledge of the medical efficiency, especially if all deaths, infections and unimproved are investigated. The monthly report of the superintendent to his or her board should be a useful factor in this regard. After all, the superintendent is responsible for each and every service, and as such a report from this source should cover the point in question.

If I were asked to sum up I would say the essentials of good service to the patient consists in the following:

*Firstly*—An institution equipped with efficient facilities for all ordinary and special work.

*Secondly*—A competent staff thoroughly imbued with the patient's interests first, who will diligently and promptly perform their duties and anticipate the patient's needs and happiness, prompted always by the best interests of the patient's welfare, socially and scientifically.

*Thirdly*—The establishing of such organization that responsibility can be placed, and such organization as will

permit of constant review coupled with medical staff conference, audit of medical work in the hospital and reports to boards of trustees or directors regularly.

The first question is:

"How best can patients, together with relatives and friends, be handled by the hospital authorities so as to make them feel at home and establish a confidence in the hospital and its staff, as well as a comfortable mental attitude in the patient?"

I am going to ask Mr. Frank E. Chapman, Superintendent Mt. Sinai Hospital, Cleveland, Ohio, who has been doing a great deal of work along these lines during the past months, to lead in the discussion of this question.

MR. FRANK E. CHAPMAN, Director, Mt. Sinai Hospital, Cleveland, Ohio: So far as getting the confidence of the patient is concerned, I believe the patient has manifested confidence in the institution when he comes to it, so I do not think that is a thing that should bother us very much, but it does seem to me that we, as administrators forget that a patient who comes into the institution is transplanted into an environment that he is not familiar with. To you and to me it is a commonplace proposition; it is a part of our everyday work, but to him it is a procedure that has a great amount of fear connected with it, and you and I do not set up any machinery to counteract that very definite, may I say, antagonistic reaction to procedures that of necessity must be in effect in a hospital.

First of all, I should like to make the exterior of my hospital building a little less foreboding. Next I would like to have the lobby just a little bit cheerful. The average hospital lobby has a cold, foreboding appearance as you go into it, and Dr. MacEachern says you ought to put a nurse in it. Put that nurse in there if you will, but take her out of uniform. That is the trouble—there is too much white uniform and white walls and white furniture and white this and that about a hospital. The reason for white furniture, as I see it, is because it shows up dirt. Well, that is the only good thing about it that I know of. Get away from it. You can; it is being done, and you certainly will get a much more pleasing effect.

As to your admitting room—and I am talking to the small hospital just as well as to the large hospital—if you have a separate admitting room service or if your office attaches take care of your admissions, get somebody in there that can smile twenty-four hours a day. If you can get somebody who can put into their work an under-



standing of the other fellow, then you will get a friendly attitude on the part of the patient, and if I can get their friendship, I will get their confidence.

I will recite something that I saw in our own institution. Somebody had an argument with an automobile and was brought in. The registrar was off duty and the cashier, whose sole job is to get the money, happened to be at the admitting desk, and here was the conversation: "Oh, yes, he's all right—now who is going to take care of his bill? Well, yes, his leg's broken—but who is going to take care of his bill?" That is all there was to this girl's attitude—"who is going to take of the bill?" Understand we must collect the money and sometimes it is hard to collect, but you can make them like it and collect it just the same. We have adopted a system of furnishing all of our attending men a printed card with all the rules and regulations of the hospital, and when there is any real doubt as to a patient's ability to pay, we may talk to them at the front desk, but is it not a whole lot better as a routine when a patient is admitted into the institution, to take them upstairs, put them to bed, make them comfortable and then talk about it afterwards?

Mr. Jones is rather hypersensitive about his wife's condition, and he says something to the head nurse. "She's all right." Sure, as far as the head nurse is concerned, she is, but not as far as he is concerned. You do not get that sympathetic understanding, and the only way you can get it, as I see it, is by constant and personal supervision by somebody who is working with their heart instead of their head. That is why we have introduced into our institution, in addition to all these mechanical procedures, a very definite routine, either by my associate or myself, at least three times a week. Understand, I have no fault to find with our nursing or housekeeping rules or anything of the kind, but I want to get in personal contact with my patients. Folks, that is where the small hospital renders a degree of service that we large hospitals do not render, and it is an attempt to get into the larger hospital a part of the very definite good that the small hospital renders, that I am attempting these reforms.

We put a card in bills calling attention to the fact that we like to feel, of our patients, that they are guests to whom we are extending a true hospitality; that in so far as we may have their point of view of our service we desire to know it, and ask them to give us any com-

ments that they may have to make, requesting that they not consider these comments in the nature of a criticism, but as the only basis we have of judging whether or not we have been successful with them. You would be surprised at the good you get out of those cards. They are unreasonable once in a while, yes, but if you will follow those up you will get more good than you expect. (Applause.)

CHAIRMAN MACEACHERN: Would anybody else like to say a word on this subject before we pass on? If not, we will take up the second question: "What should be done in the matter of the following up of patients to the end in order to ascertain in what respect the organization of the hospital did or did not function to the entire satisfaction of the individual?" I would like to ask Dr. Herman Smith, superintendent of Michael Reese Hospital, Chicago, to speak on this question. He is very much interested in this subject and after we hear from him I hope somebody else will be prepared to make some remarks on it.

DR. HERMAN SMITH, Superintendent, Michael Reese Hospital: The question of follow-up is generally taken care of in two ways: (1) during the patient's stay in the hospital; (2) after the patient has left. The problem is handled during the patient's stay in the hospital by different institutions in a number of different ways. In some of the larger institutions rounds are made by the superintendent or one of his assistants. In the smaller hospitals rounds are generally made by the superintendent of nurses or the superintendent himself or herself. In addition to rounds by the superintendent of nurses, Michael Reese has an individual order or menu taker, a person connected with the dietetic department, visit private patients daily to take individual orders and hear complaints. Many trivial complaints about coffee or toast being cold come up and the mere fact that the patients have spoken to someone about it removes any dissatisfaction the patients may have and they very generally feel that their subsequent meals are very much better than they actually are.

As far as the ward patients are concerned, I think the administrations of most hospitals that have social service departments get a pretty good idea how their patients are taken care of, because the social service workers, having a fairly independent point of view, are not remiss in criticizing any type of treatment they think is wrong.

After the patient leaves, we have adopted a scheme of sending out follow-up letters addressed to the patients personally, telling them what the aims and ambitions of the hospital are and asking them to freely criticize the hospital service. One of the hospitals, after trying this a short time, found that they received answers to about 40 per cent of the letters they sent out, and about 90 per cent of the answers were commendatory. They were about to give it up, when one of the board members who was rather inactive said that that was one of the best things he had heard of the hospital doing and strenuously objected to giving up this particular function. In the end it resulted in an inestimable amount of good in putting the community in the proper frame of mind by having them realize that the hospital knew it made mistakes, but wanted them brought to its attention so that they could be corrected. A superintendent told me today that they had initiated the same scheme, and in response to one of the letters had received a letter praising the hospital highly and enclosing a check for \$10,000. We have not received such a check as yet and do not expect to, but it shows the way the wind is blowing.

CHAIRMAN MACEACHERN: We will pass to No. 3, "How can the medical staff be made to take more interest in the clinical work of the hospital? Should there be a monthly staff review meeting, and if so, how best conducted?" I will ask Dr. George Stephens of Winnipeg to lead in that answer.

DR. GEORGE STEPHENS: Mr. Chairman, I cannot answer this question. There is no one method that will do that, that I know of, and I presume I have been asked to speak because of the possibly rather successful experiment we have conducted in our own hospital in the last two years. Previous to that, we had the usual staff clinic, in which someone showed a case, and someone else said so-and-so was to be congratulated on the result of his case, and we carried along that way until one rebellious member one day got up and instead of the usually complimentary remark, he said, "I think such and such a surgeon should be ashamed to show that case as cured. It is not a successful operation, and there is no occasion for operating that way."

That started something. Leading out of that, we evolved another type of meeting—a group meeting held in the form of a lunch.

I am a great believer in associating business with food—we do it in our hospital meetings. Our board meetings, staff executive meetings, and group meetings are associated with lunch. We have a “group meeting” twice a month, the first and third Thursdays. We have a buffet lunch at 12:30, start the meeting at 1 o’clock and close sharp at two. The meeting takes almost any form; there is a skeleton program; there may be clinical cases, may be a review of the work of the hospital, anything the superintendent wants to bring up is introduced. I find it very much better to “ask” rather than to post a notice on the board. Announcements regarding the policy of the hospital are made, any complaints I have to make or the “group” has to make may be aired. We take our coats off and go to it, and there is no particular consideration for anybody else, except that they are in the end most amicable, and I think these meetings are doing good.

The doctor brings up the case himself, or the director of records, or the pathologist; but more and more frequently the doctors are showing their own cases that have not been successful, because it is from the unsuccessful cases that we get more than from the successful cases. Whatever type of case is shown, the discussion is absolutely free. Anyone showing a case must be prepared to defend his statements from every possible angle, anatomical, physiological, pathological or the question of technique, and the discussion is exceedingly plain. We did, coincident with our adoption of the minimum standard of the American College of Surgeons, try—what shall I call it?—the “exposé” sort of meeting. We have heard of a doctor being put up on a platform with a spotlight on and made to explain why he did “so and so.” That might work all right in some places; it may be desirable in difficult conditions to actually show a man up; but our idea is that you gain very little by shaming people. We deal with these cases, sometimes by name and sometimes not. The average attendance at these meetings is about seventy.

The doctor may hesitate on consultations, x-ray examinations and that sort of thing. At first cases were shown from the general ward only; now, frequently private cases are being brought up, and the fact that a man was prepared to get on his feet and show or read his case reports and ask the advice of his confreres was a big step.

The habit grows and we are getting the consultations in the private ward cases and it is still further reacting to ordinary office and private practice. These meetings and the spirit fostered there; not for any definite action taken, but the spirit and the educative aspect of it are a benefit to the patients in our city.

CHAIRMAN MACEACHERN: Would anybody else like to speak on this important question? You all have an interest in your hospitals, I am sure.

DR. WEISS, of Pittsburgh: After twenty years' experience in one hospital, we found that one of the most advantageous times for clinical conferences was the noon-day luncheon. Some hospital superintendents might say that is a very expensive proposition, but if the hospital would serve a very light luncheon each day to its staff it would prove profitable in the end. It will be a daily occurrence for the staff to discuss their cases there and, furthermore, it will help to do away with any little dissensions a staff may have, because people cannot sit down to the same table and have differences, or cannot have them very long. So I say that instead of a monthly dinner, have daily luncheons.

The second point is, instead of having a staff conference where the spotlight is thrown on a man's weaknesses, have the presentation of records from the record room. Incomplete records should always be shown up, regardless of who the offender is, whether the chief of staff or the junior staff man. That case record presentation could be regulated very nicely through the record clerk and a committee from the staff, which committee could be changed from year to year. That committee each month will meet at stated periods and all records which are incomplete will be presented at the staff conference. In that way the hospital records will be brought up to a high standard. You might ask, "How will that arrangement improve the patients' attention?" It will do a great deal, because anything that is incomplete will be discussed and corrected. Furthermore, at this staff conference the deaths during the month can be analyzed. This does not mean that if a man happens to be on a surgical emergency service and has ten deaths and another in the medical service has only one death, that the surgeon is at fault, but the point is, did that patient receive every possible attention, including consultation? Of course, if it is an emergency, possibly consultation was not available at that time, but any patient in the

hospital two or three days or longer should have a consultation if that patient seems to be going on to termination. If consultation is not held, it is the fault of the man who had charge of that case and should be corrected. In this way the conferences can be brought up to a higher degree of efficiency, but an analysis or review of successful cases means nothing, such records may properly be presented at a medical society, but not at the hospital conference. At the clinical conferences not only the staff but the nursing staff and everyone connected with the welfare of the patient in the hospital should attend, including doctors, nurses, superintendent of nurses and social service worker.

CHAIRMAN MACEachern: I promised President Baldwin to be through at 4 o'clock, but he says go ahead, so I am going to suggest that we continue till half-past four, and if we are not through then we will act on what you wish to do. We will take No. 4: "What should be the proportion of nurses to patients in a general hospital caring for pay and non-pay cases and having eight hour service for nurses in training?"

MRS. CLARK, of Indianapolis: I think the proportion of nurses to patients in a hospital of this type should be one to two.

CHAIRMAN MACEachern: Are there any other opinions? In answering the question it would be better to consider it on a basis of eight hours, as most training schools are adopting this policy. If you had a hospital of one hundred patients you would have to have fifty student nurses.

MISS ROSE Z. VANVORT, Superintendent, Stuart Circle Hospital, Richmond, Va.: In a department of twenty-five patients we assign eight student nurses.

MISS EITL: Where you have a great many private rooms, fifty nurses to one hundred patients is not sufficient, as private rooms require more nurses than wards. We average one hundred patients and have seventy nurses, which is not too much, in fact, it is not quite enough.

MRS. CLARK: The question definitely stated they were non-pay patients, Mr. Chairman.

CHAIRMAN MACEachern: Yes, the question calls for non-pay patients. Anybody else? I think it has been for years generally accepted that one nurse to two, two and a half or three patients was satisfactory. It is a very good proportion. We will go on to the next question, No.



5: "What is the best procedure to keep correct records of all infections occurring post-operative in the hospital?" I would ask Dr. Joseph Howland, superintendent of Peter Bent Brigham Hospital, to lead in the reply.

DR. JOSEPH HOWLAND: Assuming you have a good record system for your ordinary diagnosis, not post-operative, why not apply that? For instance, you may admit a patient with bronchitis, pneumonia or erysipelas or infected wound; any one of those things may occur as a result of an operation—simply write the word post-operative; therefore, we have bronchitis post-operative, pneumonia post-operative, etc., and file away that record and when you come to look up the cases, run up those cards the same as any list of cases you might wish to look up. They will fall into one of a few classes, either local infections or perhaps general infections or respiratory infections. It seems to work well.

CHAIRMAN MACEACHERN: Has anybody else anything to add to what Dr. Howland has given us? I feel sure he has covered it very fully, a complete record system will reveal all these conditions. We will now take up the next question, No. 6: "Should the various services as orderlies, cleaners, maids, etc., be under the control of the head nurse in the ward or department or should they come under the control of their respective department heads?"

MR. PLINY O. CLARK, Superintendent of Presbyterian Hospital, Denver, Colo.: It seems to me as a general rule we should say they should be under the one who hires them. Let us take, for instance, the orderly; if he is hired by the head orderly, he should be under that orderly for certain general training, and the general responsibility as to uniform, hours of meals and hours of service, hours off duty, should belong to the head orderly; but the care of the patient should be the responsibility of the head nurse of that ward. I would not say that the head nurse should teach the technique to that individual orderly. It should be the duty of the head orderly, if he is competent, to coach the subordinate in all of his duties most carefully. You may not secure a perfect service in this double responsibility, but you will arrive as nearly as possible at perfect service if the head nurse of that ward and the head orderly work together for the one end, that of perfect service to the patient.

You can apply this scheme to the other departments. For instance, the housekeeper hires her cleaners. If ward

A is to be cleaned on Tuesday, the cleaners proceed to ward A on the appointed hour with their buckets, their soap powder, their ladders and whatever is necessary. When they enter the ward, they are under the direction of the head nurse so far as to which side shall be cleaned first and how the patients shall be moved about, and all of that. That is where the authority of the housekeeper ends. The head nurse, however, does not say whether the powder shall be put on the wall directly with a moist sponge or whether the wall shall be wiped off with water first, or just what the procedure is; that is the business of the expert you have hired, your housekeeper. To get the best service you must then be on a constant lookout for the little frictions which will come up but which can be cleared up in round table discussions between the various heads of your departments, and that is where the skill of the superintendent of this very complicated business known as a hospital comes in.

CHAIRMAN MACEACHERN: We will go on to the next question, No. 7: "Should operative cases other than emergency be in the hospital long before operation? If so, what length of time and what pre-anesthetic and pre-operative treatment in general is desirable?"

DR. A. K. HAYWOOD, of Montreal General Hospital: It does not seem reasonable that any case, whether operative or otherwise, should be in the hospital any longer than is necessary; so if you state that operative cases should only be in the hospital before operation for the necessary length of time to confirm or make a diagnosis, you will get that question answered. What is the necessary length of time would depend entirely on the class of case. You may have a gastric ulcer; if that patient has a mouthful of bad teeth, you won't think of sending him down for operation until his mouth is cleaned. If you have a thyroid case, you won't think of sending that patient down for operation until his metabolism rate has been attended to; and every case should have the diagnosis confirmed by whatever scientific method the hospital has at its disposal. Thyroid cases are at the present time in the limelight. We had an unfortunate experience last week in my own hospital; a perfectly sound, although ill, exophthalmic goitre case came into the hospital, a private patient. The patient came in the night before and went down for operation next morning. The operation was to be a simple ligature under local anesthetic. As the surgeon picked up the hypodermic needle to give the patient the

injection of novocaine, the patient died. That patient's mental attitude should have been studied by the physician sufficiently to have seen that that patient should have been in longer than over night. The patient had a thymos gland six inches long and an inch and a half wide, but nevertheless the patient died under very unfortunate circumstances. I remember some other cases we had last summer of ordinary hernias, and we had a most unfortunate run of pneumonias following the hernia operations which took place while the chief surgeons were off duty. On investigation, the surgeons were prone to state it was the ether. We have a system now whereby in every case of sudden death in the hospital we have a commission composed of members of the medical board to investigate how, why, when and where that patient died. On investigation of these hernia cases, we found that one of the junior surgeons had been referring them from the out-patient department and operating on them next morning without a careful chest pre-anesthetic examination. I am not going into a detailed account of how to prepare the patients; that is unnecessary; but the patient's chest should be thoroughly examined; an ordinary routine examination should be proceeded with before any patient other than an emergency case is sent to the operating room.

MR. ASA BACON: This is rather an important question from the patients' standpoint. It is a daily occurrence with me for patients being admitted to the hospital to ask this question, "How long will I be here, or how long will it be before I have my operation?" Now, as superintendent, what can I tell them? I always tell them that that is a matter entirely for their attending physician to decide, that they are in the hands of the doctor that they are assigned to. It seems to me that the superintendent cannot lay down any rules as to how long a patient will remain in the hospital for operation and that this is entirely in the hands of the surgeon that the patient is assigned to.

CHAIRMAN MACEachern: The next question is No. 8: "What are the essential requisites in satisfying the hospital patient from a food standpoint?" I asked Dr. Kellog, of the Battle Creek Sanatorium to open the discussion on this subject, but he told me his assistant, Dr. Charles Stewart, might be present and lead in the discussion. Is Dr. Stewart here? If not, will somebody else speak to this question. It is a very important point.

While somebody is thinking or preparing to speak, may I mention that there are three essentials in respect to this, in my opinion? First, purchasing of the food should be done in a competent manner by one who knows and according to well defined specifications. Second, the cooking or preparation of the food should be done properly and under the supervision of one who is an expert cook; and the third, which is very important and where we get many complaints, the serving of food cold or unpalatable or not daintily arranged dissatisfies the patient and is a great waste. These are three points, and the latter is very important. Possibly this will come up in the dietetic section later.

Question No. 9 is: "Should medical men write histories on all cases or see that this is done, and how best can this be secured (a) from private patients, (b) in a hospital of forty beds with no interns?"

DR. BACHMEYER, of the Cincinnati General Hospital: Since receiving Dr. MacEachern's letter asking me to lead in this discussion, I have been pondering over the reason why he should ask me to do such a thing. I have had no experience with private patients and have been in very few forty bed hospitals. I have had some correspondence and communications with some of them, and I realize that both parts of this question are very important ones. I can only give you my opinion. In my opinion, medical men should be definitely responsible for a competent, complete medical record in every case. They should either prepare it themselves or see that it is done, whether the patient is a private patient or a public patient.

In the forty bed hospital we must rely entirely upon cooperation. I do not believe that you can force the physician. Every hospital should have an organized staff, if it only has six beds and if that staff is only two or three men, and we should endeavor to have them endorse the movement that is crossing the country for adequate and competent medical records, and having endorsed that movement, have them work out the way in which the work required shall be done. I know that that is easy to say and hard to do in many cases, but I fear that it is a question that we must put up to them, and then, after they have acknowledged that it is proper to have medical records, we can obtain their assistance in securing them.

Often the doctors will say that adequate and competent medical service can be rendered without the scratch of a pen, and I agree with them, but I also say that in 999 out of every 1,000 cases it will not be done unless they put their findings down in black and white. I know that they hedge and evade the issue before they will put down on paper, at least, certain facts concerning their private patients. I see no reason why they cannot use a code of some sort, easily understandable among themselves, for significant facts concerning the case, such as venereal infection, psychiatric conditions, etc., on the records, or the elimination of patient's name from the records and the use of a code for the identification.

DR. HUDSON TALBOTT, of the Missouri Baptist Sanitarium, St. Louis: I should like very much to emphasize what has been said on this subject. I am vitally interested in it, happening to belong to the committee in our hospital which is endeavoring to stimulate the writing of better histories of our patients. In every line of human endeavor today there is great progress. Times are no longer what they were, and the hospitals of our country must keep abreast of the times; and if we will do that, we cannot neglect the writing of adequate, competent histories of our patients, and that should be done in at least a twenty-four hour period after their admission into the institution. The physician in charge of the patient, I hold, should be held responsible for that history. True, you can use your interns for that purpose, but see that your interns write a real history. If you depend on the intern to write your history, and then never read it and never take it up with him directly, you will find that you are having precious little written. Physicians should be urged to read that history and take it up with the intern and show him where he has fallen short or commend him if he has written well. This thing should not be neglected in any of our hospitals.

A lamentable fact it is, that many of our physicians, especially if they have been out some time, are incapable of writing a comprehensive history. You need to do a little bit of schooling in your staff meetings. Do that; take up some ideal history, discuss it a bit, and above all, call to time any physician who turns in a history for filing away that has been incorrectly written. There should be a committee to see that all of the histories should be properly written and that proper progress notes have been made from day to day as the case progresses.

REV. A. G. LOHMAN, of the Deaconess Hospital, Cincinnati: This is a question in which I am vitally interested, because it is a question we are going to have up in our staff meeting next time, and something is going to happen. We are a private hospital. When I went on my vacation in August, I called the interns in and said, "See here, doctors, when I come back I want the report from the office that you have written a history on every case." I was not back twenty-four hours before both interns were in. They said, "Mr. Lohman, we want to do what you say, but tell us how. Tell us how we can get a history of a woman in a private room. We have been insulted and we think that the patient has a right to insult us when we, who have nothing to do with her case, try to get a history."

As to physical examinations, I would not submit my wife to a young doctor's examination, physical or otherwise, and if I am not going to submit my wife to it, I do not think that we should ask any woman or the daughter of any family to do it. I think that the attending physician and only the attending physician is responsible for the history of any case. We have it solved in the maternity department. The girls in the office are instructed to send our regular history form, with questions thereon, to the attending physicians about a month preceding the date, with a letter (mimeograph letter), "This lady, Mrs. So and So, has been entered for our maternity department for such and such a date. Enclosed please find the history sheet which we will expect you to file when the patient comes in." We are having very good results.

We have no trouble with the men in the ward; the house physician is glad to take the history for his own experience, he is glad to take it for the benefit of the hospital, but, as I say, when it comes to a private room patient, a woman, it is the attending physician's duty, and only his, to furnish us with the history.

CHAIRMAN MACEachern: We have five minutes left. I would like a show of hands. All who would like to wait and finish these six questions. (A large proportion of the audience held up their hands.) We will continue until they are finished.

MR. ASA BACON: We are getting away from the question just a little bit here, because it says "in a hospital of forty beds with no interns." This question came up at the round table session last year, and all of you who



have the Annual Proceedings can get information from that, but I will add a few words as to what we are doing as the Presbyterian Hospital. The attending men who write the history of their private patients in their offices send a carbon copy to the hospital to be attached to the history. Another way for the hospitals that have no interns is to use the dictaphone. Busy doctors will use a dictaphone when they will not write a history.

DR. B. A. WILKES: It is no longer a question as to whether we should write a history or not; the American College of Surgeons has decided that. They came around to visit our institution last spring, and they said, "You do not come up to our standard, to our minimum standard." I said, "Why, doctor?" "Because your records are incomplete; you are 100 per cent every other way." I go to the visiting physicians of that institution—and these patients are largely private patients; we have a few ward patients, fifty or seventy-five or one hundred, the rest are private patients. I go to the visiting physicians and say, "You must write your histories; I will not let your patients leave the hospital until you have completed your record. You must do your follow-up work and make your diagnosis and final discharge or request the intern to do so."

They come to me and say that this patient has been to my office. I have a complete history on file; I have a follow-up system with these people and having nothing to do with a history for your hospital. If you want a history for your hospital from this patient, you have a perfect right to get it; you will not get it from me, certainly not. I have nothing to do with providing a history for your hospital. I have my own history at my office and I keep a card system instead of a sheet of paper system, and I cannot make a carbon copy from that card. It is up to you to take care of your own history; if your hospital wants one, get it. We are not going to take the time to do it and we are not going to hire a stenographer to go around gathering up histories for your hospital. That is your business.

I would like to know your experience. This is an important question.

DR. C. W. MUNGER, of Milwaukee, Wis.: I should like to take issue with the gentleman who preceded Mr. Bacon. I hold a brief for the intern. In my experience in a hospital of approximately one hundred beds, which handles, I should say, 95 per cent private patients, perhaps the

best class of people in a city of half a million population, the interns take all the histories. I rather feel that this gentleman must have had a poor class of interns or handled them in such a way that he did not get the best work out of them, to hold such an opinion of their work. In my opinion, the young men now graduating from the medical schools are as high in their moral and ethical standards as any of the older practitioners; for that reason I see no advantage in keeping them out of the private rooms. In the two and a half years we have been in our new building, I know of only two instances in which a woman has refused to have the intern not only take the history but do a physical examination. We do not have pelvic examinations of women done by the intern except on the order of the attending physician, but they are done if the attending physician orders them, and there is no confusion about it. The intern in many cases gets a better history than the attending physician; he follows the form which the hospital has found to be the most approved for its work, and can get the very best results. In some instances our doctors do send us copies of the history that they have taken in their office, and it is a help. But even in those cases, unless it might be a nervous patient or unless otherwise contraindicated, the intern takes the history, and in so doing instructs himself. If the hospitals which handle large numbers of private patients prevent their interns from seeing these patients who constitute the bulk of the cases treated, the intern in that hospital gets a very meager experience. For this very reason many hospitals of the type mentioned have had serious difficulty in getting interns. In our small hospital we are able to get men from Johns Hopkins, Harvard, Rush, and schools of equal standing. We do not pay them any salary either. It is because we give them real opportunity for work on all cases in the institution that we are able to attract them.

REV. A. G. LOHMAN: The gentleman misunderstood my position; it is not I keeping the interns out, but the interns want to be shown how they can get reports.

MR. WILLIAM MILLS, of the Swedish Hospital, Minneapolis: This little discussion in regard to the doctor's responsibility to the hospital superintendent reminds me of a little incident from Fort Snelling, Minnesota where I served as a Y. M. C. A. Secretary during the war, devoting the greater part of my time to the wounded and sick soldiers in the government hospital there.

It was necessary for the "Y" secretary to wear a uniform, though his uniform was not the same as a dough boy's, nor did he carry a gun. This my little seven-year-old daughter had often noticed.

One evening as we were waiting for the street car to take us home and a soldier happened to be walking back and forth on guard duty near by with his gun at shoulder-arms my little girl would look first at the soldier and then at me and finally back at the soldier again. At last she had summoned up enough courage and said, "Say pa, you ain't a real soldier, anyhow, are you?" I am not a doctor and I have often, as superintendent been reminded of this remark, when I as a layman have tried to tell the doctor what the hospital expects of him, and yet I know that every fair minded doctor will feel that he is under obligation to the hospital and its management in just the same way as the hospital in turn has a debt of obligation to the public. We have had no difficulty on that score, nor do we look for any and I cannot understand the attitude of the doctor who is reported to have said "Let the hospital get its own records."

In regard to the taking of personal histories and physical examinations I wish to say that we have pretty much the same system at the Swedish Hospital in Minneapolis as they have at the Presbyterian Hospital in Chicago. After a visit from doctors of the American College of Surgeons to inspect our hospital, we got a little busier than usual. I sent out a circular letter to the staff men and asked them if they would not please send us carbon copies of the case records of their hospital cases. Cases they had outside the hospital did not concern us, but cases that came into our hospital, we felt concerned us; we were under obligations to the patient; I, in turn, was under obligation to the Board of Trustees of the hospital and to the American College of Surgeons that had rated our hospital. I asked the doctors in case they did not send us carbon copies of the personal histories and physical examinations, that they would order the interns to take those histories and physical examinations. There has not been a single objection and wherever the carbons have not come in, the interns have taken the personal histories and the physical examinations. Occasionally, however, a patient would be brought into the hospital too short a time for the intern to get satisfactory history. This has now been corrected at our hospital. A system that we have been using and which we think is quite efficient is

this, that when the patient comes into the hospital, the admitting clerk gets the name and assigns the patient to the intern on the service under which the patient would come. The slip goes to the intern and he sees the patient and takes the personal history and physical examination, if he is supposed to, and returns the slip to the record office which brings it into my office, and in that way we have a perfect check on the work which is done.

It ought not perhaps be necessary to employ such checks upon the work of interns and yet the intern too, is human and liable to error and to forget. I think we will find that our men, our surgeons and doctors, have a feeling of loyalty to the hospital. We have private patients primarily in the Swedish Hospital in Minneapolis and there is once in a while someone who is a little touchy, but with a little tact and proper handling on the part of the doctor who brings in the patient and on the part of the intern I do not see why there should be any difficulty in getting a good physical examination and personal history in every case.

CHAIRMAN MAC EACKERN: In reply to your question, Dr. Wilkes, my experience with a large hospital is as follows; an order was issued giving three choices to the doctor; write the case yourself in longhand, dictate it to a stenographer if you wish in the record office, or, thirdly, leave an order for the intern. Ninety percent of the men in our hospital, where there are 210 men, left an order for the intern. I assured them that no unnecessary examinations would be made; our senior intern looks after that. The anaesthetic examination spoken of today gives the approach of the intern to the patient, and incidently in looking over the chest, they can get more history. With your operating rooms so ruled that the surgeon must dictate to the stenographer at the close of his operation, as we have in a large number of hospitals, you will get very fine histories, and I have had to cut our surgeons down in writing histories. They not only filled one side of the paper but the other side starting way back. By such means as that we are securing as satisfactory a private history as we have public history. Of course we have a large institution, a large record department and stenographers, which all hospitals cannot have, but in that way we are covering it mostly now by an intern service. Has anybody else anything to say on this question before passing to the next? The point which you are all impressed with I am sure is that you must have

records. That is first and secondly you must get them in some way, and there are several ways. The next question, number 10, was asked by a training school, a hospital where there are over three hundred nurses in training, where the cumbersome load of dual duties was almost beginning to ask for a change. If that question cannot be answered satisfactorily, we will transfer it to graduate nursing service be more satisfactory in the the nursing section, but I will read it; "Would the undergraduate nursing service be more satisfactory in larger hospitals if the applied nursing service be separated from the instructional division, that is, with two departments, the applied nursing as carried on in the wards, and the instructional department, both being separate but properly correlated?"

MISS RIDDLE: Without having given this question much thought, I hardly feel justified in taking your time, but just on the surface it appears to me that I should answer the question by saying no; I believe that the instructor especially the instructor in practical technique, should have access to the wards at all times, and should visit the wards during the time when those procedures which she has instructed her class in are being carried out. She can then see whether her instructions are being carried out, and can also in that way, keep trace of the uniformity of work in the hospital, which is always a good thing.

CHAIRMAN MACEachern: You agree that the theoretical side should be carried on by the University?

MISS RIDDLE: Oh, yes.

CHAIRMAN MACEachern: The practical side cannot be separated from it. Is there any other discussion on this question? Now, if you will give me the privilege I want to answer question number 11 myself, because I can say "yes" because we have tried it successfully. We give a ten months' course to technicians, two months in record, graduate nurses four months, extra technique four months, routine laboratory work and that nurse is able to go into the smaller hospital and carry on these three services; if the hospital has less than fifty beds perhaps she can also help the superintendent. She gets experience getting records, making sure that the hospital gets records in some manner, but she also learns about classifying and cross index. This is a work for the big hospital. In British Columbia we are doing it for British Columbia. We are training these girls for our small hospitals in the provinces, but you large hospital people must open your

doors to such technicians to go to your small hospitals in the different states. Big hospitals must open their doors to give this instruction. You can do it, it is the easiest thing in the world to do it. If you get the right class of girl, they get this work and go out competent. Question number 14 "How can the Board of Trustees be impressed more thoroughly with the crucial importance of the patient rather than the monetary side of the hospital?"

DR. W. P. MORRILL, Superintendent of the Shreveport Charity Hospital, Shreveport, La.: I have found that the interest of the trustees, is, as a rule a reflection of the interest of the superintendent. I assume that the superintendent attends the trustees' meetings; if he does not, he cannot hope to accomplish much any way. I assume that he does not make it an occasion for telling his troubles. The best answer I know is that in the presentation of the monthly report, the financial part be made so detailed that the Board does not want to bother to read it at the meeting; that is, make a detailed financial report, both of income and of expenditure, not only worked out according to the uniform system of accounting, but reduced further to cost per patient per day, because that is the unit and will always appeal to a business man. If it is a large hospital, follow that with a graph showing the monthly fluctuation in each item; they won't read it, but they will take it home and you will have plenty of time to talk to them. Recite the troubles you have had with patients and with doctors, not the little petty things but the definite complaints that have something to do with the care of a patient, take each complain as a text to gradually educate your trustees into the medical side. I grant you that the layman superintendent will have more difficulty with this than the physician or the nurse, but even the layman can do it, and he will soon find that his Board is interested in the medical side, and particularly in the medical statistics, particularly if you give them the cost per day and the death rate just on an equal basis, because these are the two tests of a hospital's efficiency.

CHAIRMAN MACEACHERN: The next question is No. 15, what should constitute a monthly medical report to the Board of Trustees?

DR. TANNENBAUM, of the Jewish Hospital, Philadelphia: In discussing this question it is taken for granted of course that the hospital trustees or Board of Directors should be informed of everything going on at the hospital.



It is customary for every hospital to issue an annual report, describing in detail the work of the past year. In the Jewish Hospital, with which I am connected, we have put this plan into effect every month, and issue a monthly report which is practically the same as the annual one, covering the work of the hospital for the past month. Every department head submits a monthly statistical report to the superintendent. These reports, after being received by the superintendent, are commented upon by him textually, bringing out the important parts of the work performed by that department for the month, and comparing it also with the work performed by that department for the corresponding month of the last year, so that the report is statistical, comparative, and textual. In commenting upon the reports of the different departments, the superintendent may pick out some phase of it and compare it to other hospitals in the same city. The receipts and expenditures are analyzed in the same way, giving the reasons why some are higher or lower than for the corresponding month of last year, other parts of the report considered of importance, or of interest enough, being commented upon in the same way. After the report is completed by the superintendent, it is mimeographed, a copy of the report being placed on the desk of every member of the Board of Directors at the regular monthly meeting, the report being read by the Secretary, and discussed by all those present.

The advantage of such a report is very evident, the Directors are informed exactly of what is going on, the superintendent telling it to them in as plain language as possible, and the members of the Board of Officers are at the same time enabled to study these reports at their leisure, copies of them being taken home and filed for future reference.

CHAIRMAN MACEACHERN: We will pass to the next question, No. 16, what cases should be segregated from the general ward of the hospital other than the infectious? Is there anybody here who can answer that in a few minutes? In case there was not anybody, I made the following notes: Typhoid fever; tuberculosis; skin diseases which are contagious—I think most skin diseases, because they are rather alarming and disgusting to other patients; sore throat; erysipelas; meningitis; anterior-poliomyelitis; mental cases; alcoholics; delirious, and I would say noisy cases of any kind, and odorous cases. Are there any others you think of? Is that too many? We

will pass on to question No. 17, should the private laundry of the patient be done in the hospital laundry or not? Now that is a very important question. I hope some of you will discuss it. "Should the private laundry of the patient be done in the hospital laundry or not?" (Cries of no.)

CHAIRMAN MACEACHERN: The last question is, what is the best way to have accurate and satisfactory information given out to relatives and friends regarding the patients' condition?

DR. MORRILL: I have tried everything, I guess. The old custom that we used eight or ten years ago, of sending down a sheet in the morning with the patient's condition on it, always made trouble. If somebody didn't get the sheet tangled up, some change in the patient's condition occurred after it was made out and we gave out some information that afterwards proved very embarrassing. Not all hospitals can afford a private branch exchange running to each floor. In the larger hospital, the private branch exchange is the solution of getting the information for the relatives; but the big problem is not so much getting the information *for* the relatives as getting it *to* them. The right person on the telephone is what counts, the person who won't say "Oh, he died last night at ten o'clock;" We have lately read in the journals of system and business efficiency, etc., very much about the value of the right sort of a private branch exchange operator. The clerk in the office whose duty it is to answer the calls is the front that we put up to the public, and not a position for some ill-paid employee or probationer nurse put there because you cannot use her anywhere else. It is one of the most important places to have good judgment and a pleasant voice.

The meeting then adjourned.

## GENERAL SESSION

September 13, 1921, 8 P. M.

President Baldwin in the Chair.

PRESIDENT BALDWIN: It gives me great pleasure to introduce Dr. Haven Emerson, who will address you on the subject of the Government Hospitalization Program for disabled returned veterans. Dr. Emerson.

DR. HAVEN EMERSON: Mr. President, ladies and gentlemen, Guests and Members of the American Hospital As-

sociation: I have been in the enviable position for the past eight or nine months of being responsible, in a measure, for the distribution of the beneficiaries of the Government who needed hospital care. I shall report to you upon the experience up to the present time with the largest hospitalization system that has been organized by the Government except under war conditions. It seems perhaps absurd to call attention to the size of the hospital program here involving up to the present time only some 28,000 beds when there were operated under American surgeons and physicians at one time 200,000 beds in the A. E. F. for the men in active service, and all of the beds occupied. It may seem strange that there should be any question of a hospital problem for ex-service men in times of peace with all the resources of the country at their disposal. When at short notice, it was possible to create a hospital system of 200,000 beds under war conditions in a foreign country with an insufficiency of labor, transportation and supplies; but it still remains one of the astonishing facts that a good hospital system for the care of the diseases and disabilities contracted in service has not yet been developed in the United States, and it is for your consideration as the technical experts in this field, to determine why this has been and how it may be remedied so that that criticism may no longer lie against the government.

## MEDICAL AND HOSPITAL CARE OF BENEFICIARIES OF THE UNITED STATES VETERANS' BUREAU

In its simplest terms, the original War Risk Insurance Act of October, 1917, and the various amendments, including the latest one, signed by the President on August 9, 1921, creating the Veterans' Bureau to administer all the benefits provided by the Federal Government for men and women who served in the military or naval forces of the United States during the World War and were separated from service under honorable conditions, in addition to providing for various forms of United States Government insurance, call for the payment of compensation and the furnishing of such reasonable governmental medical, surgical, and hospital services and supplies, including prosthetic appliances, as may be useful and necessary.

Although I am certain that I could count upon your interest in any or all phases of the government's undertaking to do an intelligent piece of medical and educational reconstruction work for the ex-service men and women of the World War, I shall confine myself chiefly to those features which bear upon the claimants as patients, the provision for the medical treatment at present, the plans for further development of medical services and such matters of rating disabilities for compensation purposes as have a bearing upon the medical work of the Bureau.

Those who are eligible for medical care and treatment are primarily the claimants who have been found to be suffering from a disability of service origin which is of more than 10 per cent degree. The trainees of the former Rehabilitation Division of the Federal Board for Vocational Education, now the Rehabilitation Division of the Veterans' Bureau, are also entitled to medical care and treatment for any disabilities which interfere with the prosecution of their vocational training, whether or not such disabilities are of service origin or are due to their own willful misconduct or are intercurrent or accidental diseases and injuries.

The Sweet Act (August 9, 1921) now provides that medical and hospital care shall be given to all properly accredited claimants who have disabilities of service origin even if these are of less than 10 per cent.

There will be the class of those persons who have previously applied for compensation and have been denied compensation (and consequently medical treatment) because their disability, though admitted to be of service origin, was of a degree less than ten per cent. All such persons who present themselves to the district offices or suboffices or duly authorized government hospitals and present an honorable discharge and suitable evidence to the effect that their disability has previously been found by the Bureau to be of service origin but of less than ten per cent degree, such as an official rating slip, or disallowance notice, or a letter from the Bureau of War Risk insurance, are entitled to examination and medical care and treatment for the service disability, if needed.

There will be numbers of ex-service men who have never hitherto applied for compensation who will now apply for medical care and treatment under the new provision of the law. All such persons will be called upon to execute the regular claim for compensation (Form

526) and to submit the customary papers. Inasmuch as it is necessary, before treatment can be given to them, to ascertain from the military or naval authorities the military or naval status of a claimant and his medical history, such claims for treatment will be handled in the same manner as any claim for compensation and no treatment will be given, except in emergency cases, until advice has been received from the Bureau at Washington that the person is eligible.

Medical care and treatment for this large class of claimants not previously entitled to treatment will include the furnishing of prosthetic appliances if necessary to remedy a disability or injury of service origin or aggravation. This, of course, does not include the furnishing of glasses to correct defects of vision due to congenital errors of shape, size, or conformation of the eye ball lens or cornea, unless there is shown to have been an aggravation distinctly due to service and not the usual result of age and use of the eyes.

All persons honorably discharged from the army and navy, who can show proof of the same, and who are in need of emergency treatment, but whose disability for which treatment is requested has not yet been determined to be of service origin or to have been aggravated by service, shall be promptly provided with medical care and treatment, and this emergency treatment, if necessary, may be continued until a definite decision as to the service origin of the disability is reached by the Bureau.

By emergency treatment is meant such treatment as is required to meet a true medical, surgical, dental, or mental emergency in the understanding of medical practice. This provision (Circular No. 140) is not intended to cover operations of choice, interval operations, reparative dental treatment, treatment for chronic inflammations of nose, throat, ears, eyes, or other organs or tissues, chronic rheumatism, indigestion, or the like. The emergency must be shown and described in reporting treatments given to any persons accepted as honorably discharged veterans of the World War who have not submitted evidence to prove that the disability for which they claim treatment has been declared by the Bureau to be traceable to service.

It is not intended or provided by the law that all and sundry ailments of any discharged soldier, sailor, or marine, regardless of service origin or aggravation, shall receive medical care and treatment, but only those dis-

eases or injuries due to service shall be treated, whether they are of 10 per cent degree of disability or less; and where the disability is more than 10 per cent, in addition to medical care and treatment, the compensation in proportion to the degree of reduction in earning capacity provided by Section 302 is payable.

An ex-soldier who is receiving training as part of his rehabilitation may be treated for disease or injury which interferes with his training whether or not the disease or injury is of service origin, or is more or less than ten per cent degree.

It is believed that only in very exceptional circumstances will hospitalization be required or justified where care and treatment is furnished in cases of disabilities of less than ten per cent degree.

Admission to hospital for treatment of those with minor (i.e. less than ten per cent) disabilities who are found to be entitled to such treatment will not be authorized unless it is quite apparent that the object and expected result of such hospitalization will be the removal or definite remedy of the disability. It must be clearly explained to claimants requesting hospital care for disabilities of service origin of less than ten per cent degree that hospitalization will not, of itself, establish the right to compensation or entitle them to temporary total ratings for the period of such hospital care and treatment.

Any man or woman who served in the military or naval forces of the United States during the war who brings reasonable evidence that he or she was discharged under honorable conditions, may receive medical care and treatment for an emergency condition even prior to filing a claim, the making of an examination, or adjudication of the claim to determine the service connection of the condition, if in the opinion of the medical officer faced with the situation there is a reasonable presumption of service origin and evidence that a real medical or surgical emergency requiring treatment exists as regards the disability of presumed service connection.

A further condition under which medical care and treatment may be given is when authorization for admission to hospital is issued by a responsible medical officer of the Bureau for the purpose of establishing the true nature and extent of a disability of a claimant which can not be arrived at in other ways.

Payment by the Veterans' Bureau for treatment of service-incurred disease or injury in those subsequently



found to be eligible for compensation and medical care and treatment by the Government, may be made if it is shown that the claimant was not at the time aware of his rights and privileges under the law, or found himself in such place or condition that he could not avail himself of authorized government services even if he did know he had a right to them.

According to the weekly report of hospital service as of August 18, there were 18,527 patients in government hospitals and 9,490 patients in hospitals under contract with the government, making a total of 28,017 patients in hospitals.

There were ninety-three government hospitals in use and approximately 800 contract hospitals, showing, therefore, an average of 199 patients per hospital in government, and twelve, approximately, per hospital in contract hospitals.

There were 5,826 vacant beds in government hospitals. The Bureau has contracts with 1,590 hospitals.

Charts of hospital services will show the rate of increase for the three main groups of patients, general medical and surgical, tuberculosis, and neuro-psychiatric, also the ratio of government and contract beds used, and the per cent of beds vacant from week to week in government hospitals.

According to the respective services of the government their 18,257 patients are distributed as follows:

13,454 in hospitals operated by the U. S. Public Health Service,
1,239 in army hospitals,
763 in navy hospitals,
2,266 in hospitals operated by N. H. D. V. S.
805 in St. Elizabeth's Hospital of the Department of Interior.

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Total 18,527

Of the 28,017 patients in all hospitals

9,524 are classed as general medical and surgical,
10,916 are classed as tuberculosis,
7,577 are classed as neuro-psychiatric.

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Total 28,017

and the vacancies available in government hospitals for these three groups of patients are respectively:

3,934 for general medical and surgical.  
1,477 for tuberculosis,  
415 for neuro-psychiatric.

Total 5,826

The number of patients in all hospitals has increased from 10,000 on January 1, 1920, to 21,000 on January 1, 1921 (or at the rate of 917 a month), and to 28,017 on August 18, 1921 (or at the rate of 936 a month).

Since this report the beds available and suitable for neuro-psychiatric patients have been so far further restricted that on August 26 when an insane soldier was discharged from the Letterman General Hospital of the Army at San Francisco, the only government hospital which could accept him was St. Elizabeth's at Washington, D. C., and he was transferred there with an attendant. At no time during the past year and more has there been any shortage of beds in government hospitals for general medical and surgical patients, and the same may be said for the past six months with regard to tuberculosis, but at no time even up to the present has the distribution of beds for tuberculosis patients been such that all patients needing care could be provided for in or near the vicinity or even the state or the district of their residence.

With regard to hospital facilities for neuro-psychiatric patients, it has been true since the beginning of this undertaking that there have been insufficient beds for the number of patients of this class known to be in need of institutional care, and many of the beds available have been so located and served as to be unacceptable according to the most modest standards. This is in part, at least, merely a reflex of the grossly inadequate facilities for either preventive, curative, or permanent domiciliary care of mental cases for ordinary civilian needs in almost every state in the Union. Instead of supplementing the pitifully insufficient service of the states in this matter the federal government has aggravated the crowding in state institutions while at the same time making such insignificant additions to government institutions for mental cases that at no time has the increase of beds kept pace with the growing need of the ex-soldier population.

With regard to the three large classes of patients, above referred to, it is well to consider in what way war service altered the number of such patients in the age and sex groups of the population who were in the military and

naval forces. Without entering upon a statistical analysis for which this paper does not permit the space, it is entirely within the truth to say that aside from the deaths directly and immediately the result of combat conditions, the existence of general medical and surgical diseases and injuries of ex-service men and women is no greater than would have been the case if these same individuals had been engaged between April 17, and November 11, 1918, in the occupations appropriate to their age and station. In other words military and naval service, apart from actual conflict with the enemy, was no greater hazard than industrial, commercial, and agricultural pursuits for the same age and sex groups. The same number of people would have needed general medical and surgical care if there had been no war, the chief difference being that the cost and provision for such care would have come from private or community resources instead of through Federal taxes and departments.

In the tuberculosis field, we learn that the incidence of pulmonary tuberculosis discovered among ex-service men from the Canadian forces has been about twice what would be expected from the previous civilian experience of Canada in similar age groups. The statement cannot be made upon medical statistical evidence that any such increase of tuberculosis has occurred among the United States ex-service men and women. It would appear from civilian experience in all parts of the country that neither war nor the influenza epidemics have caused any increase in the development of active pulmonary tuberculosis among men or women, white or black, of the ages used in military and naval services.

Although it is probable that many experiences, particularly on the sea and in the areas of offense and defense in Europe, were more severe than those in civil life and possibly contributed to a development into activity of previous infection by the tubercle bacillus, it is equally true that never in the history of our country were so many men so well fed, so well clothed, and so trained and developed in hygienic living as were those in uniform during the war period, and they formed a class of selected human material.

Although any statement at present must be made with a reservation as to proof to the contrary on evidence to be obtained only from analysis of the case records so far not classified for medical purposes, I believe we are in the presence of no greater incidence of tuberculosis and the

need of beds for tuberculosis patients of the ages of our beneficiaries than we should have faced if there had been no war.

With the neuropsychiatric group of claimants the situation is quite different, for here, through private and official channels, we have reasonably accurate evidence that most of the disorders of conduct and many of the organic diseases of the mind and central nervous system have appeared in numbers two to four times as great as would be expected from past civilian experience with people of the age group we are dealing with.

For the best estimate and calculation as to probable incidence of diseases and injuries connected with service to be expected in the immediate and remote future you are referred to House Document No. 481 which represents the study made on this subject by the former medical adviser of the Bureau, Dr. W. C. Rucker.

The charts indicating graphically the approximate dates when the maximum number of patients of each of the three main groups of diseases together with the actual experience since the date of the estimates (October, 1919) disclose the unusual correspondence between which was a scientific guess, but none the less a guess, and the facts as they have developed.

The gradual taking over of the greater portion of the load from contract to government hospitals has in the main progressed parallel with a steady improvement in the character of the care given to all our beneficiaries, so that now it may properly be claimed that the general medical and surgical patients receive care equal to the best the country affords. The care of the tuberculous has made substantial gains in the past six months, and only in the case of neuropsychiatric patients have the conditions of crowding, inadequate number, and training of attendant personnel been such that we can only feel shame for the failure of the government. Jails, poor houses, and state and county institutions are in use for our patients which fail miserably to meet the standards of modern psychiatry for curative or custodial care.

Upward of 160,600 patients had been admitted to hospitals as beneficiaries of the Bureau up to August 1, and on the experience of the Civil War veterans we may expect a total of 450,000 to 500,000 patient admissions before we reach a period in which care is domiciliary rather than hospital in character. The above figures in-

clude readmissions or multiple admissions of the same beneficiary.

While the government agencies have succeeded in keeping fairly abreast of the hospital needs except in the case of neuropsychiatric patients, in many cases hospital care has been a last resource rather than an ideal solution for the needs of the individual case.

Except for the special psychological elements in the diseases of the beneficiaries of the Veterans' Bureau created by the experiences in service and developed further during the period since discharge by the unusual relations of the ex-soldier to his government and society, the ex-soldier patient differs in no respect in his injuries, diseases, and needs of treatment from his fellow citizens of the same age group.

Modern medical care of the sick, though complex and elaborate, consists of a few well defined services which may be briefly designated as:

1. Out-patient or ambulatory care.
2. Hospital or bed care, including occupational therapy and prevocational training.
3. Convalescent or after care.
4. Medical social service, follow-up, or personal home service.
5. Vocational training of certain groups, the tuberculous and neuro-psychiatric cases.
6. Records for statistical analysis to control results and determine future needs.

For out-patient care we have what are generally known as:

- A. General medical and surgical dispensaries.
- B. Neurological, or more properly, psychiatric clinics.
- C. Dental dispensaries.
- D. Individual general medical practitioners, specialists, or designated examiners, dental practitioners, or dental examiners.

With the exception of three psychiatric clinics under private control with which the Bureau has contracts for dispensary care and treatment, and the use of individual specialists called upon for office services in individual cases, all the out-patient or ambulatory care has been up to the present time provided by the Public Health Service.

No other government agency has anything to offer in this type of medical services either in medicine or dentistry. The care and treatment provided through the designated medical examiners and the designated dental

examiners has been on authorization of the regional or district medical and dental officers.

It is believed that the need for organized dispensary care will be greatly increased by the provisions of the Sweet Act. In general and except where administrative reasons forbid on grounds of efficiency and economy, it is considered best to have all the dispensary services operated by the Public Health Service for the present, and gradually taken over at such places as the Public Health Service cannot justify the operation of dispensary activities for its own functions, by the Veterans' Bureau, under district organization.

The use of private or non-government dispensaries is not believed to be practicable or desirable for beneficiaries of the Veterans' Bureau. Where conditions require it, the Veterans' Bureau will have to operate out-patient services, medical, dental, and psychiatric, in connection with the necessary examination services, to determine the disability and feasibility for training of claimants.

It is believed that the government policy should be to transfer gradually from other government agencies to the National Home for Disabled Volunteer Soldiers the care of the veteran sick and if necessary and desirable in the future, absorb this under the Veterans' Bureau, relieving the Army, Navy, and Public Health Service of their responsibility for care of ex-soldiers in hospitals as inappropriate and detrimental to the best functioning of these government services.

The national home for disabled volunteer soldiers is considered to be the logical government agency for the permanent care of the sick and dependent of the World War, and their organization and equipment are more capable of providing for this now and of expansion for the additional burden expected in the future than any other government agency.

There are so few facilities of any kind which might be called convalescent homes or hospitals that this necessary element in care and treatment of the sick may well be said to be non-existent.

It is believed that between 5 and 10 per cent of the patients discharged from general medical and surgical hospital care should be provided with from two to six weeks' convalescent care in government institutions operated as part of existing government hospital organizations or under the administrative control of a medical officer of the Veterans' Bureau, under district organization.



There is no hospital social service for hospital patients of the Veterans' Bureau provided by any government agency at present, although there is some medical social service contributed by the American Red Cross for patients of the Public Health Service hospitals who are beneficiaries of the Veterans' Bureau. There is a small nucleus (eighty) of trained medical social service workers employed by the Rehabilitation Division of this Bureau, formerly of the Federal Board for Vocational Education, operating from the district offices.

There is a small group (200) of visiting nurses whose functions are in some measure those of medical social workers among the trainees who need medical care during training. There is a considerable number of trained social workers serving under the American Red Cross who assist in following claimants to obtain medical and occupational and social information to establish compensability and feasibility, and to keep track of the patients discharged from hospital. Neither in number, direction, nor organization do these various nurses and social workers supply the needs as understood in modern medical practice. It is believed that a section of personal service should be created in the Bureau to provide for the reasonable and proper after care and home follow-up of disabled veterans of the war, and that a medical social service be provided for by the government for all government hospitals caring for beneficiaries of the Veterans' Bureau.

The profession of social service has come just in time to take on the burden of re-creating the character of beneficiaries of the government. At present the colossal generosity of the government is ruining human character and personal endeavor and initiative among ex-service men and in so doing is causing more social disability and inadaptability than it is curing; is teaching men to say they cannot work; is teaching men to develop and continue symptoms for the dollar; and is reversing the proper relationship between patient and physician. The M. D. that convinces the man he is sicker than he thinks is praised as a benefactor. A hospital has become a boarding house for financial ends; a school and training center, a place for postponement of self-support. A claim is a gamble. We are reverting nationally to the charity and political hand-out phase of government subsidy and turning our back on the principles of that justice which is another word for social service.

The attitude of the newspapers, of Congress, of the ex-service men through their official spokesmen is in direct opposition to the principles of social justice. Facts as to relief and hospital care are intentionally misstated for the sake of exploiting public sympathy.

Vocational training camps or centers under medical direction have been established under the Federal Board for Vocational Education and are now being extended under the Veterans' Bureau. Those so far put into operation have been for neuropsychiatric patients. It is believed worth trying as a medical undertaking for selected groups of epileptics, and possibly as have been done in one instance in England for certain types of arrested tuberculous patients.

The question of records for statistical analysis is entirely within the hands of the Veterans' Bureau and requires direction and personnel, and a plan for filing and indexing records as already outlined by a committee of statisticians in December, 1920, but so far not undertaken. Without a cross-index card giving for each case the vital and medical information required, it will not be possible either to check the quality of current medical services or to plan intelligently for the future. The Veterans' Bureau owes the country such a record keeping and report as will supply a true supplement to the medical history of the war now in preparation by the Surgeon General of the Army.

The following extracts from official letters recently sent to the district medical officers indicate better than a prolonged description, some of the pressing current problems of a hospitalization:

"Hospitals are built, equipped, and administered for the sole purpose of providing for accurate diagnosis and complete, adequate medical care and treatment for patients who need such an elaborate, complicated, and expensive service and cannot be as well cared for by outpatient or dispensary service, by home nursing or personal service follow-up, or convalescent home care, or vocational training. All these necessary services in addition to the care and treatment provided in hospitals must be actively developed at government expense as constituting recognized and necessary elements in adequate medical services for all varieties of patients.

Many hospitals where patients of this Bureau are admitted have been found to have patients who do not belong in any hospital, should not have been approved for

admission to the hospital in the first place, should not have been accepted without protest by the commanding officer to the district medical officer even if referred or retained as patients if once admitted. This unsuitable, ill-judged, and inappropriate use of hospitals, constitutes one of the present abuses under the War Risk Act.

No matter what the appeal to give a claimant housing, board or lodging, hospitals must not be used in this way to give the equivalent of material relief. A claimant or beneficiary may be admitted to a hospital if by that means alone a complete and conclusive diagnosis can be arrived at, or if his condition is such as to require hospital care. A hospital is not a terminal dump heap for human derelicts, but a shop for human salvage; not a convenient place into which district organization can unload its troubles, but part of a broad scheme of medical service for carefully selected patients who need the medical, nursing, laboratory, and specialist care obtainable in no other way.

A patient in a hospital is a liability for all concerned, and not an asset. Every day he stays in hospital beyond the time of absolute necessity he meets otherwise avoidable risks and accidents of infection, exposure to undesirable impressions and contacts, and the government is running up an unnecessary expense account, both of which responsibilities are quite unjustified.

The object of hospitalization is not to establish, maintain, and continue the status of total temporary compensation, but to diagnose and treat the sick, and in so doing to accomplish so much by treatment that a prompt and reasonable reduction in compensation due to diminished disability may be determined.

It is the responsibility primarily of the district medical officer, or district managers, to establish such standards of examination and control of authorization for admission to hospital as will admit to hospital only those patients for whom he cannot get adequate diagnosis or treatment by any other medical or social resources.

It is the duty of those in charge of all hospitals to which Veterans' Bureau patients are referred for admission to notify the district medical officer through the district manager at once when a patient at the Bureau is no longer in need of hospital treatment and arrange for prompt discharge irrespective of the effect this may have on compensation or insurance. To base duration of hospital care upon financial benefits or advantage to the

patient is unsafe and unsound. Discredit is brought upon the various government services and upon our control of contract hospitals when any criterion for duration of hospital stay is used except professional medical judgment as to further benefit to be obtained by hospital care.

When those in charge decide that a patient needs no further care or has reached maximum improvement under the conditions which can be provided at the hospital, they should arrange for the patient's discharge. Much remains to be done in providing those necessary out-patient and home follow-up service, under governmental or private auspices, especially for tuberculosis and neuropsychopathic patients which, if well organized, would not only serve to prevent many patients from needing hospital care but would provide such resources that hospitals could with safety and advantage to the patients discharge patients at an earlier stage of their convalescence. Hospital dispensary and hospital social services or their equivalents are the protectors of our over-crowded hospitals. They are the front and back doors of the hospital and should serve the patient coming and going.

Two auxiliary services urgently needed in every district, and especially in or near the large cities, are a neuropsychiatric clinic, and a convalescent home. The Bureau will give prompt consideration and encouragement to recommendations of district medical officers and district managers for establishment of these fundamental utilities.

Since June 30 there has been a considerable and sharp increase in the total number of beneficiaries or claimants of this Bureau admitted to hospital care.

This is remarkable enough at this season of the year in any hospital system or service, being contrary to government and civilian hospital experience throughout the country, but appears even of greater moment when the character of the admissions are considered.

If this increase had been among neuropsychiatric or mental patients, for whom there have been at all times and still continue to be altogether inadequate facilities, as to character, location, and number of beds, it would not be strange to find at any time a great increase in admissions because of the steadily growing pressure for the hospital or institutional care of these patients, whenever and wherever more beds could be made available for them. There has however been less increase in the hospital census for these patients than for either of the other classes of patients (i.e., tuberculosis or general medical

and surgical patients). The increase in neuropsychiatric patients in hospitals from June 30, 1921, to August 11, 1921, was 175.

Also it would be reasonable to expect a marked increase in the number of admissions of beneficiaries of the Veterans' Bureau suffering from Tuberculosis, as the better discipline and standard of care, the improvement of government facilities, the continuing industrial depression, and the development of advanced stages of the disease among ex-soldiers, all are combining to develop a flow of these patients from their homes or private care to hospitals serving the Veterans' Bureau. But here again the increase has been moderate and in fair accord with experience in tuberculosis in the hospitals of the civilian population at this season of the year. The increase in tuberculosis patients in hospitals serving the Veterans' Bureau from June 30, 1921, to August 11, 1921, was 311.

When we look however at the increase in admissions of patients under the heading, general medical and surgical patients, we find an astonishing state of affairs which requires sober consideration and action by district medical officers. From the first of February, 1921, until June 30, 1921, the admissions of general medical and surgical patients remained each week at almost exactly the same figure, the weekly hospital census for the entire country for these patients varying only between 7,945 and 8,576 in this period. (Increase of 631 in twenty weeks.) In other words, at the time of year when normally we have the largest increase in general medical and surgical hospital admissions for all groups of the population, the claimants and beneficiaries of this bureau have shown but slightly increased need for hospital care. This is not only exactly what was to have been expected at this date after the cessation of hostilities, and demobilization of the forces, but duplicates the experience of England and Canada. This slowing up of admissions to hospitals, for general medical and surgical conditions in any way connected with service, indicates the peak or plateau of the load for this class of patients and may properly be expected to be followed as it has been in the experience of our allies by a steady falling off in the need of hospital care for such patients. (The peak of the load for tuberculosis may be expected within one and one-half or two years from now and that for neuropsychiatric patients within three to five years.)

In spite of this long winter and spring period of fairly constant status of hospitalization for general medical and surgical patients we note suddenly on June 30, 1921, and for the seven weeks thereafter a marked increase in the census of patients of this class from 8,401 to 9,378, a greater increase than has occurred in any similar period within a year. (Increases of 977 in seven weeks.)

It is believed from a study of the correspondence, and the admission cards and the reports of patients found in hospitals not needing hospital care that this increase is due to unsuitable and ill-judged admission to hospital care by the medical officers approving of requests for hospitalization in the various districts and to the abuse of the privilege of hospital commanding officers to admit in emergency cases those applying for treatment, but not presenting authority or proof that they are entitled to hospital care at the expense of the Bureau.

Furthermore, it is apparent that discharges of disallowed cases, and of those who wish to remain in the hospital pending adjustment of their claims but who do not require and will not be benefited by further hospital treatment have not been as prompt and effective as is to be desired.

Liberality and the most generous dictates of human sympathy do not require the abuse of hospital facilities for the sake of acquiring merit in the eyes of the various veterans' associations or placating an unreasonable public press or currying favor with state or federal officials, all of which influences have at one time or other in many parts of the country been powerful and effective in developing admissions of unsuitable patients, admission of those having no real legitimate right to government hospital care, and retention in hospital beyond a useful or necessary period.

Hospitals are for the care of the sick and it is believed that the marked increase in hospital census for general medical and surgical patients since June 30, 1921, represents not a necessary use but an abuse of hospitals and does not reflect a legitimate increase in the needs of hospital care for the beneficiaries of the Bureau.

The Sweet Act calls upon the Director of the Bureau to issue regulations for disciplinary control of patients in hospitals and such have been prepared by the Bureau approved by the government hospital services caring for our patients and will soon be issued and endorsed uniformly wherever our patients are under treatment.



The regulations treat of three main forms of misbehavior:

- (a) Leaving the institution against medical advice.
- (b) Absent without leave.
- (c) Conduct which requires discharge.

The main penalties are: deprivation of privilege of readmission, withholding compensation temporarily, forfeiture of compensation.

Except where forfeiture of compensation is ordered, in which case appeal may be made to a committee of citizens appointed by the director, imposing of penalties and putting them into effect rests with the commanding officer or superintendent of a hospital on recommendations of medical officers of his staff. Notice to the Bureau of such action is required and all disciplinary acts are reviewable and reversible by the director.

The Sweet Act also calls for the promulgation of standards for treatment. Except for the report of a committee of the National Tuberculosis Association and the American Sanatorium Association which will be used as the basis for standard requirements for the hospital or sanatorium care of our tuberculosis patients, no text for treatment standards have yet been prepared. Suggestions as to minimum requirements for hospital care of the sick have been received from the American Hospital Association and National Sanatorium Association and in the near future some regulations will have to be issued by the director.

The most important contribution yet made to the subject of national provision for hospital care of the veterans of the World War has been prepared by the consultants on hospitalization of the Secretary of the Treasury; Dr. Charles W. White, Dr. Frank Billings, Mr. J. G. Bowman, and Dr. George H. Kirby, who, in association with specialists from governmental and private agencies have studied the source of patients, their distribution by states, districts, classes of diseases, etc., and at the same time the existing government facilities for hospital care with a thoroughness which justifies entire confidence in their conclusions.

This consultant group was created by the Secretary of the Treasury to advise him as to the best way to use the appropriation of \$18,600,000 (Langley Bill, March, 1920) devoted by the Congress for building additions to existing government hospital establishments of the Public Health Service and the national homes for disabled volunteer

soldiers, and new hospitals for the care and treatment of beneficiaries of the Veterans' Bureau.

The work of these consultants is rapidly approaching completion and all that can be said at the moment is that according to their plans 6,800 additional beds will be provided, 3,600 for tuberculosis, and 3,050 for neuropsychiatric patients. It is contemplated to spend \$7,917,000 for additions to existing plants and the remainder in new hospital establishments. Their report, when made public, if printed with the accompanying data, should be a most important document, and if followed, should leave its impression on hospital care of the ex-soldier for thirty years to come.

It is my belief that no more beds will be needed by the government for general medical and surgical patients and for tuberculosis patients when the projects about to be approved are completed. It is probable that an additional appropriation of perhaps \$5,000,000 to \$10,000,000 will be required to meet the government obligations for the best institutional care of mental patients, although this may not be evident for another year or so, and in the meantime the need may be met by new construction by various states for the special needs of ex-service patients.

It must be remembered at all times that under existing laws the National Home for Disabled Volunteer Soldiers must receive and provide domiciliary and hospital care of any honorably discharged veteran of the World War whether he be suffering a disability of service origin or not, so long as he is shown to be dependent and a proper charge upon the service of the Homes.

As the law specifically mentions that supplies including artificial limbs, trusses, and similar appliances shall be furnished in addition to compensation and governmental medical care and treatment, a word as to the practice of the Bureau in this matter is appropriate. Under the general heading of prosthetic supplies and appliances are included not only those needed for what may be called orthopedic purposes, but also glasses for correction of visual defects and such dental fixtures or appliances as are found necessary in the course of repair or correction of service-incurred dental or oral disabilities.

The reckless and even mischievous way in which expensive and suitable artificial limbs, braces, etc., were misused, broken, and destroyed, entailed an extravagant and profitless expenditure for this purpose by the government.

To remedy these abuses and bring the practice of the Bureau more in conformity with the procedure in effect in the army a regulation was issued by which an annual credit is issued to a beneficiary who has been supplied with a prosthetic appliance such as an artificial limb or brace for a permanent disability, which represents the usual cost of replacement and repair of his appliance, based on long civilian experience. If replacement and repairs are needed to a less extent than is represented by the credit allowed, the beneficiary receives the unexpected balance from the Bureau at the end of the year. If he exceeds the credit allowed him he will be expected to meet the extra expenses, unless it is clearly shown that the cause of breakage or damage, or loss was due to causes for which the government is properly responsible.

With the exception possibly of the beneficiaries of state or commercial compensation or disability insurance laws or contracts, no patients are hospitalized throughout the country whose conditions of care, state of mind and relation to hospital authority and medical direction are so altered from what may be called the normal as is the case with many of the beneficiaries accepted in hospitals under the War Risk Act and supplementary legislation. It is obvious that many of the difficulties of hospital administration in government and contract hospitals have arisen from the application of the section of the original War Risk Act which provides for compensation for disabilities.

Among the causes of resentment, dissatisfaction, real distress, hopelessness, lack of confidence in justice, etc., which have frequently created a serious psychological block to recovery have been first the delay in acting on claims, and next in order of importance inconsistency and vacillation in ratings, and the lack of prompt adjustment of awards, to the constantly shifting medical and occupational status of the claimant.

Furthermore the desire on the part of the government bureaus and departments to give every possible benefit of the doubt to claimants in establishing connection with service and the existence of a compensable disability was given an excuse for hospital admissions and prolonged periods of hospital care for claimants who under any reasonable and suitable use of hospital facilities would not be accepted and should not be considered as patients for bed care.

The fact that any claimant who has been declared to be suffering from a disability of service origin of less degree than temporary total will receive for the entire period of hospital care a temporary total award has acted as a constant source of temptation to claimants to seek and demand hospital service for inconveniences, insignificant sequelae, complications and one may truthfully say imaginary states of ill-health for which the private citizen would never conceive nor his medical adviser counsel hospital treatment, and all this demand because in no other way can such generous benefits be obtained.

Your proper and just comment and criticism of these conditions are thought weak and incompetent administration of both compensation and medical features of the work of the government departments is responsible for the abuses. But from personal experience, I am inclined to think that ill-advised and sentimental public opinion and the mischievous efforts of seekers for political and publicity values have been the true cause of the failure to protect hospital services against abuse.

Reference to the charts will in a measure explain the vicissitudes and fluctuations in the medical phases of disability ratings, and on the whole the records justify considerable confidence in the quality of the great majority of actions on claims for disability.

While a claim filed promptly after discharge, accompanied by recorded evidence of service incidence or aggravation of a disability, and supported by a medical examination made by a physician who has, accessible to him, hospital and laboratory facilities to establish a complete and correct diagnosis is easy to settle quickly and justly; as we progress farther from the dates of the armistice and demobilization, there is an ever increasing uncertainty in all elements of the claims.

To permit and to assist the claimant to present the strongest possible case to the government, he is encouraged and guided in obtaining affidavit proof, if possible, for even the most fanciful and unlikely story purporting to show service connection.

The following extracts from instructions to the medical officers of the districts sufficiently disclose the attitude of the medical division in this matter.

"There is usually little difficulty in the adjudication of those cases in which the official records of the Adjutant General's office show illness or injury at the time of discharge from military service, or during the term thereof;

and in which such illness or injury is related to a disability for which compensation is applied for within a reasonable time after the date of discharge from military service.

The majority of cases that have come before the Veterans' Bureau have been of this type, and they have been settled with a justice and a promptitude (considering the volume of the work handled) for which this Bureau has never received due credit.

It is in those cases in which the Adjutant General's official records are negative, and in which the application for compensation is made at a period so removed from the date of discharge from military service that it is not clear that stress of military service can be implicated, that affidavit evidence is called for.

The essential of such evidence is to establish the existence of a continuous and a material disability from the date of discharge from military service to the date of application for compensation, or from a date sufficiently close to the date of discharge from military service to create the reasonable presumption that stress of military service was a factor in the production of the disability.

The preferred form of evidence is physicians' statements. Was the man treated by a physician, or physicians, in the interval between the date of discharge from military service and the date that he applied for compensation? If he was not under medical supervision and treatment, why not? If he was, can a statement be obtained from the physician, or physicians, who treated him during that interval, setting forth just when he was first seen, when he was seen thereafter, and just what symptomatology he presented? The detail of the symptoms should be as clear and full as possible, in order that the referee rating the case may identify the condition and evaluate the degree of disability from it. Physicians' statements need not be in affidavit form.

When statements from physicians are not obtainable, consideration will be given to specific, first-hand, and disinterested statements from lay affiants. If it is the contention of a claimant that his disability arose while he was in the military service, he should produce affidavit evidence to show this from the following persons, in order of preference: (a) The medical officer or officers who treated him while he was in the military service; (b) a commissioned officer of his command; (c) two or more of his comrades.

The existence of a continuous and a material industrial or occupational disability after the date of discharge from military service is best brought out by statements from employers. When, where, and how was the claimant employed after he left the military service? If a claimant was forced to discontinue employment by reason of disability, he should produce statements from employers, and particularly from persons who were in direct personal supervision of him to show that such was the case.

All affidavit evidence should be confined to matters of fact. Expressions of opinion are not wanted, since such opinions are usually not competent.

It is not necessary that an affiant go into the condition of a claimant before he entered the military service, as many affiants do. Under the terms of Section 300 of the act, as interpreted by the general counsel, a claimant is presumed to have been physically and mentally sound before he entered military service, which removes the necessity of discussing the claimant's condition before such entrance.

Specificity as to dates is essential. Such vague generalization as soon after discharge, some time after discharge, are of no help. It should be clearly stated on or about what date the claimant was seen by the affiant.

The affiant, while refraining from expressions of opinion as to the diagnosis, or as to the causation of the claimant's condition, should, in his own words, state just what evidences observed in the claimant led to the conclusion that the claimant was disabled. Frequently, especially in psychiatric cases, the evidences of 'insanity' brought out in the affidavit are mere oddities of conduct which are clearly within the bounds of normalcy. But this cannot be helped. The Bureau will have to take this type of evidence as it is offered, without attempting to shape it. If it is sufficiently clear, and if it is specific as to dates, such evidence may contribute something to the decision reached.

What is wanted in affidavit evidence should be stated clearly to the claimant by the medical examiner at the time the claimant appears for examination. Usually it can be secured in the claimant's own immediate neighborhood. It is the function of the visiting nurses and medical social workers to assist the medical section in obtaining additional medical evidence, especially in cases where



illiteracy or errors of mentality and behavior cause confusion and delay.

The need for affidavit evidence will certainly be reduced if the medical examiner, in every instance, supplies a clear and detailed statement of the medical and industrial history of the claimant in the interval between the date of discharge from military service and the date of application for compensation.

It is not infrequent that one encounters a fairly extended military history in the medical reports from the field, which includes a record of the claimant's campaigns, etc., etc. This is unnecessary. The Adjutant General's office supplies any information of this sort that is needed. The time and trouble could be better spent on the personal history of the claimant, especially from the date that he left the military service up to the time that he appears for examination. Was he examined by a physician, or physicians, during that time? If so, where, and when? Was he in a hospital or hospitals? If so, where, and when? What was his capacity for following a gainful occupation during that period of time? When was the onset of the present disability? That should be very clearly brought out. Has the claimant had any intercurrent illness since the date of discharge, which might account for the disability for which he claims compensation? This is an important point, since the Bureau is daily receiving claims in which the disability is obviously due to some condition that has arisen after the date of discharge and with no relation whatever to such military service. It is in the interest of worthy ex-soldiers that such claims be rejected.

In tuberculosis cases, careful inquiry should be made as to the intercurrent of influenza, typhoid, etc., since the claimant left the military service. In neuropsychiatric cases the social and economic circumstances of the claimant should be investigated, having in mind that psychoses and psychoneuroses may have their development in crises not necessarily related to the claimant's military life."

The abuses of compensation privileges which in themselves bear more or less directly upon the medical services called for under the laws include the results of:

Legal decisions and reversals of opinions as in the case of Treasury Decision Regulation No. 57 and changes in the laws, thus reversing previous action.

Administrative actions by the Veterans' Bureau such as allowance or disallowance of claims, reduction or increase of awards without valid medical or social evidence and contrary to medical opinion.

Political pressure, from members of the Congress and other officers of the government who frequently insist upon the allowance of a claim in the face of convincing evidence that there is no merit in it. This commonly assumes the form of personal pressure on the medical referee or claims examiner responsible for action on the claim, and of a demand that some constituent be not discharged from hospital although his claim has been disallowed and he is in no need of hospital care.

Medical action, in the nature of medical examination reports by physicians in the field who have succumbed to the appeal of friends and patients to report conditions as serious or constituting an extreme or compensable disability, contrary to the facts when disclosed by a less interested examiner.

Press articles which for ulterior motives and in a wholly irresponsible way relate as true, stories presented by disgruntled claimants and patients who use these as means of enlisting support and consideration for their demands. This blackmail from hospital and other sources has been persistent.

Appeals by veterans and other volunteer social welfare organizations which have at times and under the pressure of sentiment and selfishness rather than sense and the dictates of even handed justice, seriously interfered with and delayed action by insisting on the merits of cases in which the evidence is contrary to the claim.

It is but a natural desire of those who have the self-assumed duty of providing for those needing some of the many varieties of social or material relief and assistance to make every effort to unload the ex-service man, his family, and his problems upon the government and this wish has often been father to the thought and demand that the Veterans' Bureau provide all that is needed even though the dependency or disease disclosed has no relation to previous government service.

These have been some of the elements which have caused that alteration in the normal relation between the sick and the well, between patient and doctor, between patient and hospital, and between the veterans' community and the services offered with a characteristic generosity by the government, a generosity far beyond what the

allied and associated powers of the war have been able to afford.

In emphasizing the elements of error, discontent, and the causes of abuse or failure of government services it must not be understood that the majority of the claimants or beneficiaries have suffered ill treatment or have taken advantage of their government's eager offer of help.

From careful studies of large hospital populations in various districts it would appear that not more than 10 per cent of our patients, and in many cases not more than 5 per cent, fall in the class of troublemakers or unsuitable recipients of hospital care, and if the margin of error in just compensation ratings were found to be as much as 1 per cent it would be a surprise. A check of several thousand claims disallowed, and reviewed for this purpose by our most mature, responsible, and experienced group of medical officers showed an error of 1/10 of 1 per cent in the decisions arrived at. Errors of compensation rating are chiefly the result of pressure to give decisions too rapidly to permit of adequate study of the merits of each case.

Without the assistance and support of the various veterans' organizations and of the American Red Cross the work so far accomplished would have fallen even further below the standards and ideals which the successive directors of the Bureau have constantly set before them.

The process of coordination now actively under way with the broad powers conferred by the Sweet Act upon the Director of the U. S. Veterans' Bureau and the experience gained in the past three years should certainly result in a more rapid improvement in administration of the benefits of compensation and medical care and treatment in the next six months than has been possible in any similar period since the inception of this great constructive program of social justice made necessary by the war.

Graphic illustrations of the experience of the United States Veterans' Bureau in hospitalization, medical services, and disability compensation for beneficiaries under the War Risk Acts:

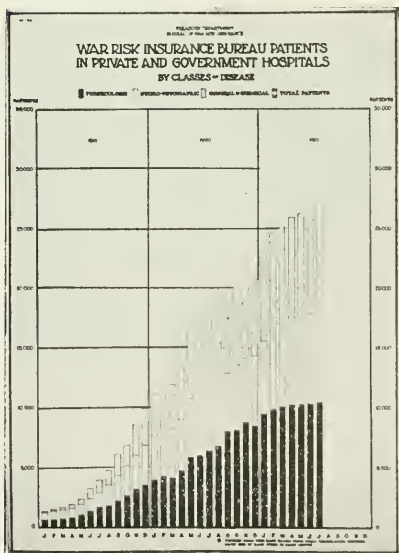


CHART 1.

From the records of hospitalization from January, 1919, to July, 1921, included, it will appear that the bulk of hospital care has been at all times for the tuberculous patients, the general medical and surgical cases coming next, and the neuro-psychiatric showing the smallest number. If there had been adequate facilities for the first and last of the above groups, the increase of these two groups would have been undoubtedly larger and more continuous. No further increase in general medical and surgical cases is to be expected, but that there will be an increase among the tuberculous patients for two years and among the neuro-psychiatric patients for five years more.

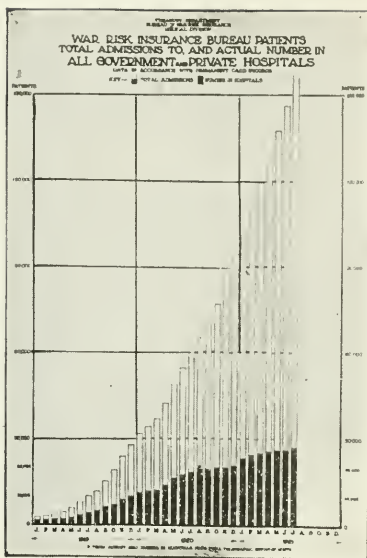


CHART 2.

In the absence of any certainty as to the extent of further benefits to be granted by the government to ex-service men and women by further legislation, and in the absence of any established or accepted government policy for the extension of hospital facilities for the neuro-psychiatric and tuberculous patients of the government, no prediction can be offered as to the probable limit to the total hospital admissions which may be expected for disabilities and injuries due to service in the World War. From study of the experience after the Civil War, it is likely that, before the work of the government in this field has been completed, approximately 500,000 beneficiaries will have been admitted to hospital care under the War Risk Acts.

THE NATIONAL ARCHIVES  
COLLEGE PARK, MARYLAND 20740

**WEEKLY NUMBER OF PATIENTS IN ALL HOSPITALS, NUMBER IN GOVT HOSPITALS,  
NUMBER IN PRIVATE HOSPITALS AND NUMBER OF VACANT GOVT BEDS**

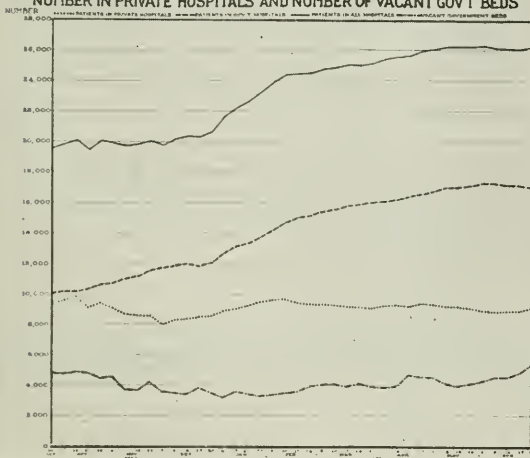


CHART 3

**HOSPITALIZATION**  
Veterans' Bureau Beneficiaries in all Hospitals

No. of Beneficiaries each Week from January 6, 1923 to 1968

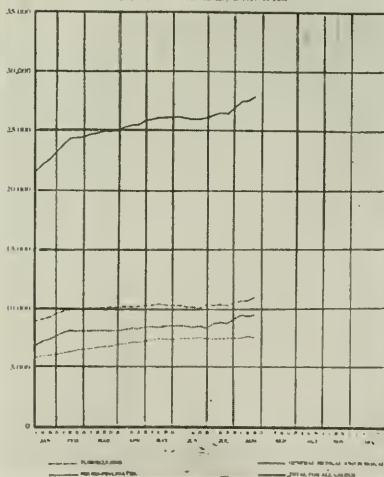


CHART 4

# WEEKLY PERCENTAGE OF ALL B.W.R I PATIENTS IN GOVT HOSPITALS AND THE PERCENTAGE OF TOTAL AVAILABLE GOVT BEDS REPORTED VACANT

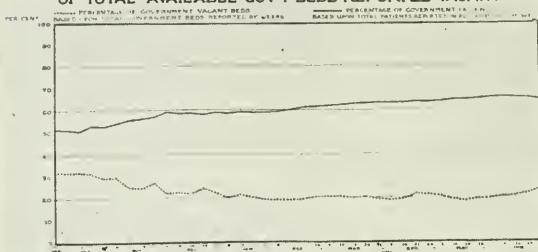


CHART 5.

CHARTS 3, 4, 5.

These demonstrate the experience which is common with all hospital systems that approximately 20 per cent of all hospital beds in operation will be found vacant because of the necessary limitations and emergencies of hospital administration and the irregularities of admissions and discharges. The constantly decreasing proportion of beds in private hospitals under contract with the government as compared with beds in government hospitals, indicates the extent to which the various federal agencies have actually provided for a larger share of the service required for the nation's wards. The fairly constant relationship in the census of the three main groups of patients, is shown well in chart 4. The sudden increase in admissions chiefly of medical and surgical patients since July indicates an improper use of the hospitals of the government for the care of many patients not ascertained to be compensable beneficiaries, and therefore entitled to care, and a retention of patients pending settlement of their claims beyond the time when their medical condition required hospital residence.

## COMPARISON OF ESTIMATED BEDS NEEDED IN ACCORDANCE WITH HOUSE DOCUMENT NO. 481 AND ACTUAL EXPERIENCE TO DATE INDICATED

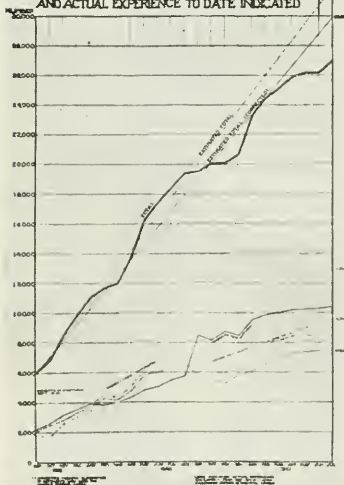


CHART 6

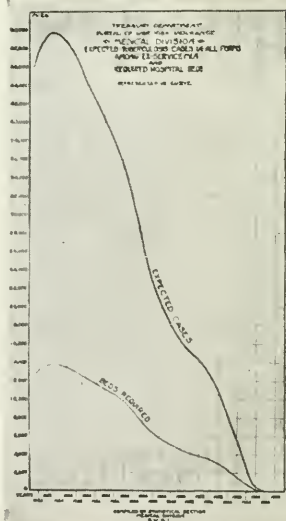


CHART 7



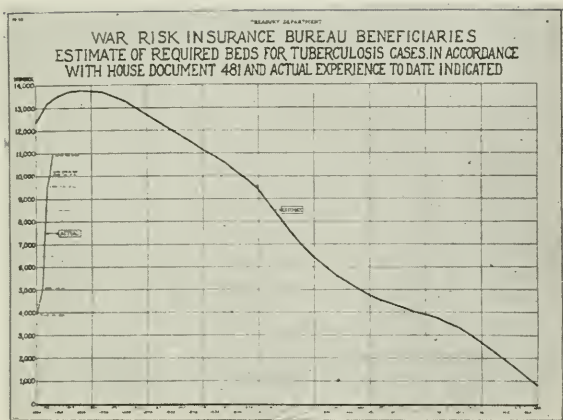


CHART 8

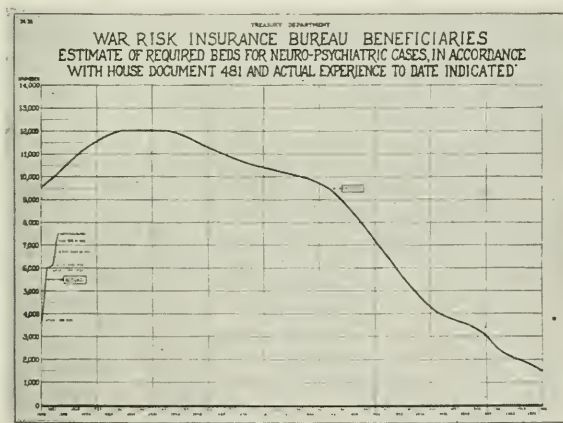


CHART 9.

CHARTS 6, 7, 8, 9.

These show the estimated hospital census calculated for presentation in House Document 481 and the actual experience (chart 6), which will illustrate the fairly close approximation between the estimate of September, 1919, the time when the charts of expectancy were presented, and actual hospitalization up to and including July, 1921.

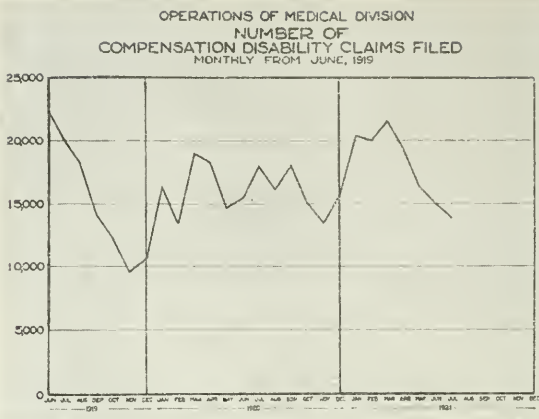


CHART 10.

Here are recorded facts which must be obvious to anyone who is familiar with probabilities of medical experience, namely that there is certain to be a steady and increasingly rapid decrease in the number of compensable cases of disabilities incurred in the service during the war—in spite of the intensive effort by private agencies, the Red Cross and the American Legion particularly, and by the organization of numerous "Clean-up Squads" in all the states of the Union by the Veterans' Bureau itself, to search for still unsatisfied and uncompensated claims under the War Risk Act for medical care and treatment and compensation. There has been a sharp reduction in the number of claims filed since March, 1921.

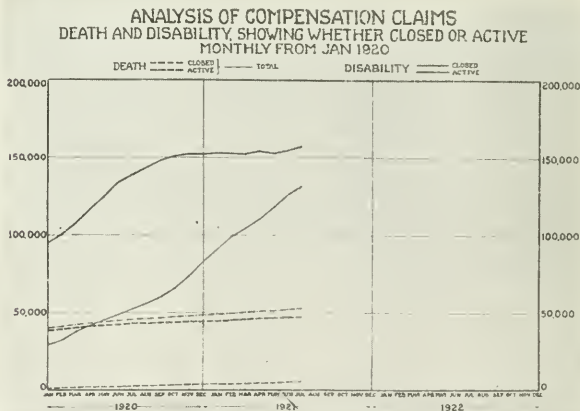


CHART 11.

This is self-explanatory, it being obvious that presently the total of disability claims closed because of the discontinuance of true vocational disability, will exceed the number of claims for which disability awards are still being paid.

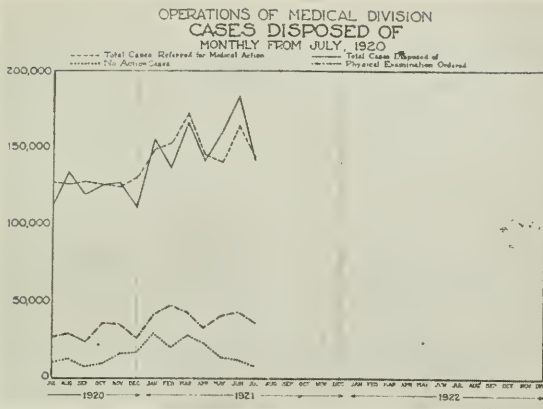


CHART 12.

This illustrates well the very considerable difficulties in adjusting personnel of the medical division to extreme fluctuation in the service expected in the case of medical rating of new claims and the re-rating of cases already declared compensable.

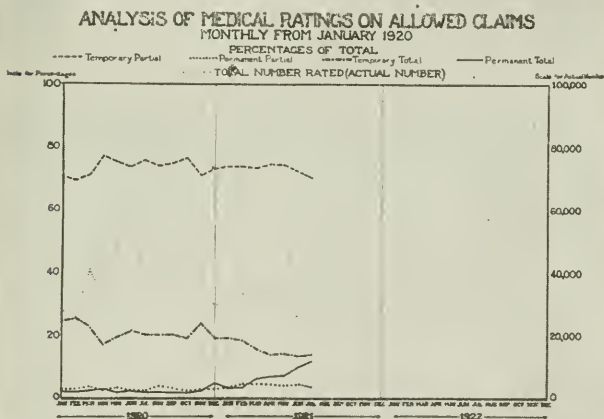


CHART 13.

This is interesting chiefly because of the record of constant increase in the number of permanent and total ratings beginning in November, 1920, and the corresponding decrease in the number of temporary total ratings. This steady change in relation of these two groups of disability awards, was due to the issue of the Treasury Department Regulation No. 57 of November 26, 1920, which automatically threw into the class of permanent disability awards all those, even those whose complete restoration to health could be confidently expected, who had been under hospital care for six months and still needed further hospital care. The decision of the controller in August, 1921, reversing this ruling will soon restore the relationship of these two groups to their normal and correct status.

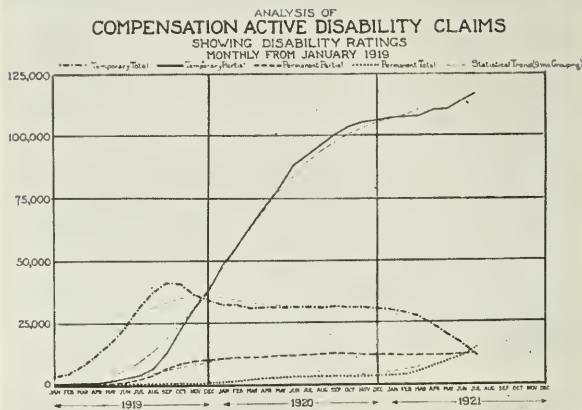


CHART 14.

This chart shows the actual number of the four classes of disability ratings by months, together with the trend of increase or decrease based on nine months' groupings. Here again the result of treasury regulation No. 57 is seen in the sudden alteration in the number of permanent total, and temporary total disability ratings.

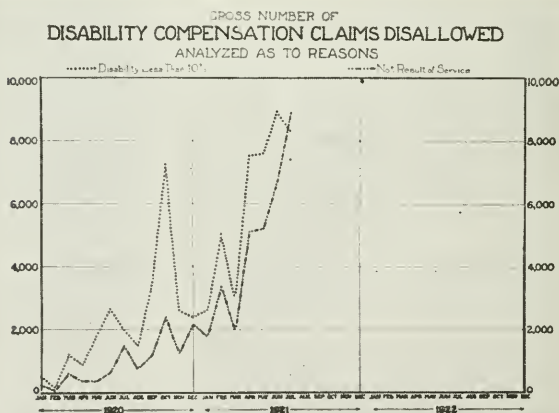


CHART 15.

GROSS NUMBER OF  
DISABILITY COMPENSATION CLAIMS DISALLOWED  
ANALYZED AS TO REASONS

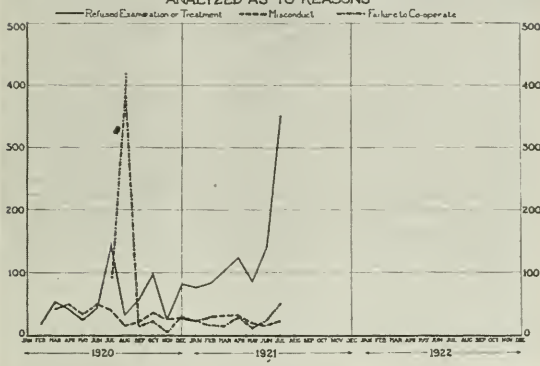


CHART 16.

CHARTS 15, 16.

Charts 15 and 16 give a graphic and striking representation of the causes for disallowing disability compensation claims. Chart 15 shows the reasons which are based on medical information and judgment as to the true origin and actual degree of disability, and chart 16 shows the reasons for disallowing a claim which may be considered administrative rather than medical in character. It will be recalled that no disability compensation award can legally be paid unless it is shown to the satisfaction of a medical referee of the Bureau that the disability claimed was incurred in or aggravated by conditions of service during the war, and that the disability constituted an impairment of more than 10 per cent degree in the occupational capacity of the claimant. The steadily increasing number of those who apply for disabilities which cannot, even by the most generous interpretation of the government, be accepted as of service origin, and for disabilities of such trifling nature that they cannot be rated as of more than 10 per cent degree is clearly shown as consistent. The very sharp increase in the last few months of these disallowed cases, is the result of the great number of incompetent claims presented in the course of the nationwide drive to reach all possible handicapped men and women who were at one time attached to the national forces.

Similarly chart 16 shows how many of those who claimed disability were unwilling even to take the trouble to submit to and obtain medical examination by which the extent and degree of the disability could be accurately disclosed. The small number of claimants whose disabilities were found to be due to what is technically known as the individual's own mis-conduct and not to events properly included in the term "in line of duty," is shown by the record of so-called "mis-conduct" cases in chart 16.

Those whose compensation claims were denied for failure to cooperate are merely instances of claimants who obstructed the necessary inquiries of the government as to their medical and social status, otherwise than by refusing medical examination. Disallowance of claims is in no way a penalty administered for any delinquency of the claimant, but is merely the necessary withholding of an award on the part of the government when it is found that the claimant cannot present, and the government cannot obtain, adequate evidence that the claimant is entitled to financial benefit under the War Risk Acts. The disallowance of the claim for disability compensation does not exclude those who have a less than 10 per cent handicap from obtaining free medical and surgical treatment for any service-incurred disability.

OPERATIONS OF MEDICAL DIVISION  
NUMBER OF  
COMPENSATION DEATH CLAIMS FILED  
MONTHLY FROM JUNE 1919



CHART 17.

This has as its main point of interest the tremendous increase of death claims filed in the first few months of 1919 and 1920 because of the widespread influenza epidemics during these periods.

NUMBER OF ARTIFICIAL LEGS AND ARMS ORDERED  
MONTHLY FROM SEPT 1919

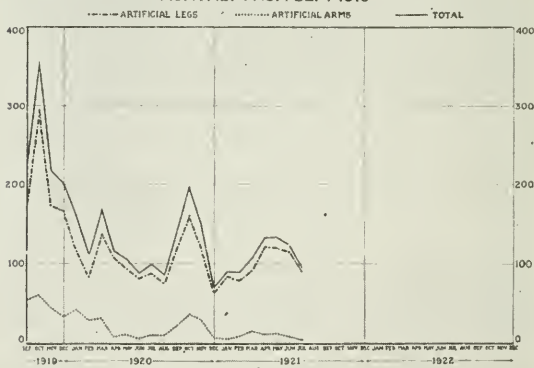


CHART 18.

Chart 18 is of interest simply as recording the bulk of assistance given by the government in the form of prosthetic appliances.



## DISPENSARY SECTION

September 14, 1921, 10:00 A. M.

Mr. John E. Ransom in the Chair.

CHAIRMAN RANSOM: It has been the purpose of this section to bring together into this meeting this morning a discussion of out-patient problems of three types of communities, the large city, the small city and the rural community. We were disappointed in the matter of a proper presentation of the problem of the rural community. Not only did they seem to be the most difficult problem, but the most difficult phase of the subject to secure discussion of, but we are going to have something about that as a part of the program. The first paper on the program, while discussing in a rather special way, the dispensary problems of a large city, will do that in a somewhat limited way. Mr. Davis is going to talk to you on the subject of cooperation among city dispensaries, and I might say, in calling on Mr. Davis, that he certainly does not need any introduction to you, that he is speaking as executive secretary of the Associated Out-Patient Clinics of New York City. Mr. Davis.

MR. MICHAEL M. DAVIS: Mr. Chairman, ladies and gentlemen: The problems of the dispensary in a large city are, of course, the same in many respects as those of a dispensary anywhere else. The way this meeting was arranged, it seems appropriate to discuss those matters of dispensary work which are peculiarly the problems of the dispensary in a large city, and chief among those are the problems of relationship to other dispensaries. In a small town or a rural area, there is likely to be only one or a very few dispensaries in a given locality, but in a large city like New York, Philadelphia, Chicago, or Boston, we find a considerable number of different dispensaries, some attached to hospitals, some unattached to hospitals, and at once a problem of cooperation arises among such a group of institutions. Now the problem of cooperation among dispensaries is different from that among hospitals in many respects, chiefly because of a difference in the patients. The hospital patient is not as movable as the dispensary patient. The dispensary patient is movable, I was going to say a movable feast, but he is not always regarded as a feast by the dispensary to which he gives

his presence. The dispensary patient moves about, has a freedom of choice, has opportunity for shifting his place of treatment, which creates certain problems. In New York City, for instance, there are something like 150 dispensaries of all kinds, of which over 75 are clinics treating the sick, the remainder being dispensaries largely concerned with public health work, such as infant welfare clinics, pre-natal clinics, etc. With such a number of dispensaries, naturally there are many problems.

Take the matter of location alone. Hospitals mostly have their out-patient departments, or dispensaries; in a place like New York the hospitals have not usually been located with regard to the distribution of population. We find in New York City and elsewhere that there will be two, three, four or half a dozen hospitals within close range of one another, each with its dispensary. In other parts of the town, particularly outlying regions, newer sections, there is no hospital over a wide area and perhaps only a single dispensary serving several square miles. We have a distribution of clinics with very little reference to the needs of the population, particularly in view of the fact that population shifts. Downtown sections in New York are actually decreasing in population, while newer sections in the outer part of the great city have increased out of all proportion to the rest; yet the distribution of facilities for medical care has very little relation to the population distribution.

One of the constant pressing problems of every dispensary at the present time is like that of many other institutions—finance. What shall be done to get enough money to keep the institution going? The charging of dispensary fees from patients is now quite general except at the municipal institutions. It is usual now, as we all know, to charge a fee of ten cents, twenty-five cents and even fifty cents for the admission of patients. That is becoming more and more true throughout the country. It is curious however that you find in the same city quite wide variations in the rates of dispensary fees. In New York City we find institutions that are charging nothing—I am not speaking of municipal institutions—nothing except perhaps a nominal fee for medicine; nothing for admission. We find others that are charging twenty-five cents, or even more. Now it is very curious that the attendants at the dispensaries do not seem to bear any particular relation to the fee they charge; because a dispensary has a high fee does not at all mean

that it may not be swamped with patients. One of the largest dispensaries in New York City, has recently been seriously considering raising its fees merely because it was so overcrowded. They were warned that it might be a good thing to raise the fee but probably would not have the effect of keeping patients away, and again and again dispensaries have raised fees without finding that patients were kept away. It is service that draws patients. It is obviously undesirable that you should have, within a few blocks of one another, dispensaries doing apparently similar work, one of which is charging 25 cents admission, the other 10 cents and the third nothing at all. The problem of getting dispensaries to come to a more or less uniform rate for equivalent types of service to be charged patients seems a very reasonable proposal, and yet that is a real problem, namely, how to agree upon some more or less uniform level of dispensary fees.

There has been in existence in New York for nine years an organization called the Associate Out-Patient Clinics, which is a body now including some 70 odd dispensaries and out-patient departments of hospitals with delegates from each one constituting the central body of the Associated Clinics. This organization was quite active before the war, was quiescent during the war, as many other such organizations had to be, and has since become active again. This organization is making an effort to render more uniform such matters as fee rates.

Now the method by which dispensaries may come together through such an organization may be of some interest. Dispensaries include, like a hospital, four main elements, the medical staff, the administration, that is the trustees, superintendent and other administrative officials, the social service group, and the nursing element, which in the dispensary is somewhat less important than the nursing group in the hospital. The medical staffs, of course, are the fundamental group in the dispensary as in the hospital, and the Associate Out-Patient Clinics have worked chiefly by forming sections of the medical staffs. One finds an active interest among men who are actually working in the dispensary clinic when they get together with other men of a similar group from other institutions and talk over common problems. The chief of hospital service gives as a rule very little time to the dispensary, yet has authority over the dispensary clinics. The men in the dispensary often have very little chance to express themselves, to make their views felt in con-

trolling, governing and stimulating the work of the dispensary itself. Groups of men working in pediatrics, for example, in 25 or 30 different clinics are brought together, one man from each clinic. They meet as the Pediatric Section of the Associated Clinics. They find at once that they have many common interests. They can discuss their methods of clinic work, their common problems and find an opportunity of learning from one another. We have found a great deal of active interest from the sections representing men in the same line of work in different institutions. Previous to the war the work of these sections led chiefly to formulating certain definite standards of dispensary work in each branch. One of the most important elements in these standards was in determining the number of patients which a given clinic with a given number of physicians, ought to take. The feeling on the part of the clinical men has been that the limitation of numbers of patients in proportion to the number of doctors and other facilities of the clinic is one of the most important element in a proper standard of dispensary work, and most of the chief sections, medicine, surgery, pediatrics, gynecology, venereal disease, etc., have through the sectional meetings of the clinical men, outlined as standards, the number of patients which they feel should be allotted per physician in a given clinic.

These standards were mostly worked out by these sections just before the opening of the war, and it was found necessary to abandon this work because so many of the men were called in service. When the war was over and the men were back, they faced at once the practical problem of how to get these standards carried out, and at once there is the difficulty as to how to control the intake of the dispensary so as to give to a given department the number of patients it can properly handle according to these standards or according to any standard, and not any more patients. That relates to the admission system of the dispensary. Without an efficient central administration the individual clinic physician cannot usually control the number of patients that he is to take; he must get those patients from the administration, as in the hospital, and he must take and do the best he can for those that come to him; consequently it has become apparent that the enforcing of a proper dispensary standard, so far as the limitation of the number of patients is concerned, is an urgent problem, which in New York City depends largely upon the proper adminis-

tration of the dispensary, and particularly of the admission desk of the dispensary, the central admission system. Consequently at the present time the Associated Outpatient Clinics are devoting attention to working out detailed methods and standards for the admission of patients, because upon this admission system must be based the control of the number of patients which a doctor should have.

It is a difficult thing to turn patients away from the dispensary; patients are disappointed, they feel badly, complaint may be provoked and yet somehow or other it must be made impossible for a single doctor to be faced with the problem of giving a physical examination and appropriate time for consideration, tests, etc., to some forth patients, new patients and old patients together, in the course of an hour. To do work of that kind means no serious medical work for most patients, and that should not be tolerated in a good clinic; some limitation of numbers is essential. I might just say in connection with that, that the number of patients per doctor is not a fixed quantity, because the amount of assistance a doctor has will determine very largely the number of patients he can handle in a general medical clinic. For example, a doctor working alone might be able to handle adequately four, five or six patients an hour, depending on the number that were old or new; he might be able to handle two or three new patients and three or four old patients in an hour, working alone. However, if a considerable part of the histories, particularly the non-medical or social parts of the histories, were taken by somebody, if the patients were all ready on the table when the doctor had to begin his examination; if the specimens for the laboratory were all taken by proper assistants, if there was someone available for giving the detailed instructions to the patient after the doctor had outlined in general to a properly trained worker, what the instructions were to be, then the doctor's time could be greatly conserved. The providing of technical assistance is a great conservation of the doctor's time, but that means money and that is hard to get under present conditions. But we cannot arbitrarily lay down fixed standards of the number of patients per doctor for a given clinic without considering the amount of clerical, nursing and social service assistants a doctor will have.

The value of bringing people together applies with equal force to the superintendents or other administrative

officials who are running the dispensaries, getting them together to talk over common problems, to work out joint standards or even to exchange ideas in an informal, friendly way. This is of great value, just as we find at these meetings here on a national scale. The formation of standards is something which has to be adapted to each community. Conditions in Boston, for instance, where I have observed them for many years, are rather different from those in New York, chiefly because in the dispensaries in Boston there is generally much less pressure of numbers than in New York, and the problem of limitation of numbers, while a real one in Boston, is not the outstanding problem it is in New York City. Each city must face certain differences in its conditions, and I do not feel that a set of standards worked out for New York City by the Associated Outpatient Clinics or any other body could be applied out of hand to the dispensaries of another city. Yet no doubt they would be suggestive.

Another problem of dispensaries in a large city of which a good deal of talk is made is the problem of the dispensary rounder, the patient who "loves to be treated," who "loves" to go about and have many distinguished doctors punch him and give him medicine, and go to the next one and compare them and talk them over with the members of his family. The dispensary rounder has been discussed a good deal, but I do not know of any serious study that has been made of the number of dispensary patients who are rounders in proportion to the total number. The trouble is that, by the psychology that we all share, if we see a patient coming several times or hear of him as having gone around to several different places, we remember that case and forget the large number who are not rounders. The dispensary rounder, however, is a real problem because he is a nuisance. Although the percentage is small, there are enough to make themselves more or less obvious. The rounder is more or less an evil which can only be checked by cooperation. The chief remedy proposed is districting. That would be simple enough perhaps if dispensaries had been located with reference to geographical considerations and to population, but in the absence of that relationship, rigid dispensary districting seems impractical. The teaching dispensaries will not agree to it, anyway; they fear to lose interesting and important cases. Personally I do not believe that in a city like New York or any of the larger cities where dispensaries have been located with reference to large hospitals,



there is much hope of districting among the chief dispensaries. I do think, however, that something can be done along the following line. The principle on which some districting might be brought about is not merely geographical but functional distribution. Take for instance, a large teaching clinic affiliated with a medical school and a hospital, and able to give a very high grade of diagnostic service and very careful study to individual patients, to patients who have come with difficult medical problems. Such a clinic is in quite a different position medically from a small dispensary treating patients with general diseases with no large body of specialties, with no elaborate facilities for laboratory and x-ray work. It would seem appropriate that, to the teaching clinics, should be referred from the small local dispensary, those difficult problem cases which the teaching clinic is equipped to study out, but for which the local clinic is not so equipped. On the other hand we find in teaching clinics cases of very minor significance, petty injuries, minor things such as colds and other small medical problems which may become serious but which, as they present themselves, do not require the facilities of the teaching clinic to be studied out and treated. There is a double problem of distribution there. To the teaching clinic or the first rank diagnostic clinic should be sent the problem cases appropriate to such an institution. On the other hand, it is a pity to lumber up such a clinic with a large number of simple, easily treated cases that could be properly attended to at local clinics less expensively equipped to maintain and near to the patient's home. Some plan by which there can be an agreement among the dispensaries sufficient to enable the teaching clinic to be provided with those interesting problem cases which naturally belong to them and no one else; and which on the other hand, can see that the local clinics are dealing with patients primarily from their neighborhood, and with medical problems simple enough for a local clinic—some plan of this sort is needed. Here is a possible scheme of distribution which will give the teaching clinics what they need and yet will give the patients what the patients need, the best facilities, and wherever possible, facilities near their homes. Now, how far this plan can be worked up it is impossible to say at this time, but some effort will be made during the next few years to see it tried out at least in some sections of New York City.

A very urgent problem during the war among all clinics was getting sufficient medical staffs. Since the war that is perhaps a little less difficult, but there is generally a shortage of medical staffs among dispensaries. The Associated Outpatient Clinics has recently undertaken to act as a sort of employment agency, namely, to get hold of doctors who want to take places in clinics. It would, of course, in no sense take the responsibility for appointing doctors or even nominating them. In the venereal disease clinics, some thirty in New York City, it is seeking to learn the number of vacancies which they have, which many clinics are anxious to have filled. How many vacancies have you in your clinic? What requirements have you for men who might fill the vacancies? On the other hand, it circulates among physicians and internes in New York City and vicinity, the knowledge that there are certain opportunities for men who want to work in venereal disease clinics, so that the men who want to apply can communicate their names and addresses to the central office and those names and addresses can be furnished to the clinics which have vacancies, the clinics making their own choice and decision. Something may be accomplished thus by having a central body acting as a clearing house for finding the vacancies that exist, on the one hand, in the clinic personnel, and on the other hand, for drumming up information as to doctors in the community who would like to have clinic positions.

Another problem that arises among the dispensaries in a large city is the problem of finance, how to keep going. Dispensaries, like hospitals and everybody else, have suffered from the present depression and from the high cost of maintenance due to the higher salaries and higher cost of materials. Dispensaries have been able, in many instances, to increase the fees charged patients sufficient to enable them to cover all or a large part of the increase in the expense, but a considerable amount of money must still be raised by many dispensaries. Whether it is possible to have any joint campaign for dispensaries is a question which is worthy of some consideration. In a number of cities there have been joint hospital campaigns, a group of hospitals getting together and trying to finance themselves by a joint appeal. The community chests in many cities have done that substantially for the hospital and for many other institutions, for all the charities of the city, but there has been nowhere, so far as I know of, a joint appeal for dispensary work. It would be imprac-

licable, of course, to have an appeal for a dispensary associated with a hospital without involving the hospital, and any plan for the joint financing of dispensaries must consider the hospitals to which the dispensaries are attached. It is quite possible that in New York the joint plan of financing a group of hospitals which has been in existence there for many years may be accompanied in the near future by a special campaign for the dispensaries attached to those hospitals. The public, however, has not as yet become accustomed to hear very much about dispensary work. Now I believe there is a considerable amount of money that can be gotten for dispensary work if the appeal is properly presented. The Boston Dispensary, for instance, has conducted two large campaigns for itself alone with considerable success in recent years, and has found a very active response to the idea of getting money for dispensary work. Dispensary service has two elements which have made it appeal to people, first the element of dramatic interest in numbers, large numbers. To the charitably inclined, numbers make an appeal, an appeal much larger than it merits, but still an appeal. Second, dispensary work has a preventive side to it and appeals to the man or woman who wants to prevent disease, keeping people at work while they are receiving medical care. The business man can be appealed to often on the ground of the dispensary's industrial value. I am inclined to think that the appeal for dispensary work strengthens the hospital appeal if conjoined with a hospital appeal, because it supplements the appeal for the bedridden sick by an appeal which brings in other aspects which appeal to new groups of people which the ordinary hospital does not reach as contributors. Therefore I think it may be helpful to combine with the hospital appeal something particularly for the dispensary so as to bring in these other elements of interest. The element of social service is often prominently represented in the dispensary and can be brought into the appeal, touching again another group of people who will give to social service as such but have not been accustomed to give particularly to medical work. The possibility of opening new sources of financial supply for the hospital and dispensary is extremely important in these times of financial stress; therefore, whether by individual appeal for separate hospitals and dispensaries or by joint action, the plan of bringing the dispensary into the hospital appeal is well worth considering. A discussion of the problem of cooperation among

dispensaries in large cities would hardly be complete without a word about the elimination of the patient who is able to pay, that is the elimination of so-called dispensary abuse. I believe that any plan which promotes cooperation among dispensaries and promotes efficient work in dispensaries will do the most that can be done to eliminate dispensary abuse, because the big abuse is not the abuse by the patient able to pay a doctor but by overpressing the medical staff so that it cannot do decent work and overcrowding the clinics so that the patients cannot get adequate service. The removal of that abuse will make it comparatively simple to eliminate that very small proportion of patients who are able to pay a doctor and yet come to get service that they should not get, because the overcrowding of patients upon both the doctor and the administrative work of the dispensary makes it impossible to decide adequately as to the patients who can pay and those who cannot. The way to correct dispensary abuse is to promote dispensary efficiency.

CHAIRMAN RANSOM: If there is no objection, we will postpone the discussion of Mr. Davis' paper until the other papers are presented. The next paper is a discussion of the outpatient problems of the small city with a suggested solution of those problems by Dr. S. G. Davidson, superintendent of Rockford Hospital, Rockford, Illinois.

DR. S. G. DAVIDSON, Superintendent of Rockford Hospital, Rockford, Illinois: After listening to Mr. Davis' very wonderful discussion of the work that is being done in New York City in the big way that it is being done, I feel that our little hospital community problem is one that is hardly worthy of attention. Nevertheless we are all hospital superintendents with a vision of doing a big work for our community through our hospital, and I am impressed more and more as I attend these conventions, that the thing we all need most is to be told how we can do the things that fit our own particular institution. I need that help constantly. I am most fortunately placed in that I am near Chicago and that I have the opportunity of being constantly in touch with the Association and with the Hospital Library and Service Bureau and with those fine people at the Modern Hospital, all of whom are so willing at all times to help; and so if this little experience that we have had is going to be of any benefit, it can only be such because it is an experience. Every-

one I am sure is interested in the dispensary, or you would not be up in this hot room this morning.

All hospital people are interested in the establishment and operation of dispensaries. They are interested because dispensaries are such a vital part of hospital service, not only for the work they furnish the staff or the clinical material they may bring into the hospital wards, but because of the great good they accomplish in improving the health, correcting the physical defects, and aiding the needy of the community.

Through its dispensary, the hospital is enabled to give aid to a far greater number of people needing such help, and at far less cost, than any other agency in corrective medical practice. In the light of all that has been written on this very important subject, there is little need, at this time, to go into a discussion of this phase of dispensaries.

Those who feel as strongly on the subject as I do will realize that a goodly part of the hospital is missing, if a dispensary is not operated in conjunction with the institution. I believe that, in a general way, we all know or feel that there is a distinct need of a dispensary in our community, or that such a service should be a part of our hospital, that there is work for it to do, that there are people needing such service, and in our thoughtful consideration of our institution, we dream or plan such a service. However, we cannot stop with the idea or the plan, because if we do, years will roll by and the need will not be filled; or, if we go to our staff and board of trustees with the general statement that we think a dispensary is needed and that it would be a good thing for the hospital, and if we make such assertions without being pretty thoroughly conversant with every detail and factor which may enter into the establishment and operation of such a dispensary or without being sufficiently posted to meet every argument which may be raised against it in any discussion of the project, we will never have our dispensary, or if it should happen to be installed on the spur of the moment, it will never be a real success.

The establishment of a dispensary must be founded on very definite knowledge of conditions, needs, and methods of meeting them. Within the past three or four months, I have had the opportunity and pleasure of establishing a dispensary in connection with one of three hospitals in a city of 70,000 inhabitants, situated 100 miles from Chicago, the hospital having 110 beds and drawing its

patients from a number of smaller communities within a radius of twenty-five or thirty miles. And the story of what was done and what has been accomplished thus far may be of more practical interest and value to you than any theoretical discussion of dispensaries, their establishment and operation.

In this city, which is a large manufacturing center, there is a working population composed largely of Swedish and Italian peoples, a small percentage of other nationalities, together with the American. The first item of interest in regard to health conditions was the absence of any dispensaries or of any health conservation activities on the part of the city government. There was, however, a state clinic being conducted once each month, more especially for orthopedic cases. As is well known, there is a very distinct sentiment among physicians against state medicine, and as the state health department sent their own doctor from Springfield to examine these cases, some of which were being sent to Springfield for operation, the local men were quite opposed to clinics and this is a condition, or rather a factor, which must be given a great deal of consideration. What is the best manner of overcoming opposition, on the part of the medical profession, in the establishment of outpatient work in small communities? For we have to bear in mind that these doctors are giving a great deal of their time in caring for the poor in their homes. The doctors care for these families when some of the members are working and they are paid for their services, and then they are perfectly willing, so they say, to go on caring for the families when the members are not working.

Our next step was to secure information, relative to the mortality rate, and this information was very meager. The baby death rate for 1920 was 80.4 per one thousand births, while the total death rate was 11.76 per one thousand population, both of which were very low, due undoubtedly to good living conditions and to high wages during the war period.

There are, however, several very active associations, the visiting nurses, the public welfare, the anti-tuberculosis society, and in addition to these, school nursing is being carried on in a manner superior to the average community. After gathering together as much information as possible, I had a long talk with one of our staff members, a leading pediatrician, who also has charge of



the school children inspection work. From his knowledge of conditions, among the school children, he felt there was distinct need of dispensary work for babies and children, more especially as there had existed, since January first, a local condition of about 50 per cent unemployment. He felt that many families were beginning to feel the pinch of hard times, that they would not be able to purchase the usual nourishing food, and with the hot summer coming on, a great deal of sickness would exist among babies and undernourishment among the children. We asked for a meeting of the representatives of the three organizations previously mentioned, for the purpose of getting their opinions. In the meantime, we looked over our hospital and found on the ground floor in the older part of the building two rooms, one a corner room, nine by twelve feet, which was occupied by a maid, and next to this a room, twelve by twenty-four. The larger room was being used to store bedding, etc., and was also used as a sewing room. It took only a short time to find a place in the basement for the bedding and also a good sewing room, so we went into the meeting with the knowledge we had the necessary space. The general sentiment at this meeting was unanimous in supporting the opinion of the staff doctor; but it was decided to have a survey made by the nurses of the various organizations to determine whether or not our conclusions were correct. This survey covered every poorer section of the city, and when the reports were turned in, we discovered that conditions were not so acute as we had thought; that men, out of work, were getting odd jobs, that they were drawing on reserve funds; that their gardens were helping them out for the summer; and that there was, as yet, comparatively little undernourishment among children. But we also discovered that families, in their effort to practice economy, were cutting down first on their milk supply. We felt that this would have a serious effect on the health of the children, so it was arranged to buy milk at a very low cost and sell it at the various playgrounds at two cents per pint, and a fund was made available for this purpose. It was, however, brought out very definitely at this second meeting, that families without income would, undoubtedly, be in need of medical service for which they would have no funds.

This meeting, then, developed the fact that there was a real need of an out-patient department for sick babies and children, and that there would probably be found

among those children to whom milk would be sold at the play centers, a few so undernourished as to need the advice of a physician. We, therefore, arranged to hold our first out-patient clinic for children on Monday, June 20. We secured good newspaper publicity, and on that first morning, seventeen children, ranging in age from nine months to fourteen years, were brought in for examination. Of these, twelve were referred by the Visiting Nurse Association and five came of their own accord. Upon examination, we found four to be surgical cases; two, mental; one, eye; and the remainder, feeding cases, three of which were children nine to thirteen, plainly undernourished. Of these seventeen cases, four were transferred to the hospital. At this point, I think it would be of interest to say that we had given careful thought to the out-patient records and had printed a form which we felt would meet every need. We only had fifty made up on the proof sheet and used these at the first clinic in order to discover where we might improve on them. They were made up, too, to fit in with our hospital records.

Our examination room was furnished with all the equipment used in our old emergency examination room and has since been used as an emergency room also. The waiting room was furnished with discarded school room benches. The hospital had never had a children's department, our pupil nurses receiving their children's training in one of the large Chicago hospitals, but late in May we severed our affiliation and recalled our pupil nurses in order to give them their children's training under our own supervision. We had foreseen the need of such a department and had purchased six five-foot children's beds and eight four-foot cribs. On the second floor of the old part of the hospital there was a four-bed ward at the end of the corridor, while outside was a covered porch. We had the porch inclosed with wire screen at a cost of \$38.00 and, with the ward, had room for fourteen children. To this porch ward went the four feeding cases, two clubfoot cases, one congenital hip case, one poliomyelitis case, and one tuberculous spine.

You may be sure this was a red letter day at this hospital, for it was also the beginning of record keeping on the part of the physicians, and the opening of a fully equipped laboratory in charge of a Class A pathologist, and our doctors were considerably keyed up. Every staff man who came in had to go back and see the laboratory and out-patient department. While the pediatrician and

myself had discussed the operation of the children's clinic in detail and while we had talked casually of the out-patient department to the other staff men, they had not taken very much interest in the matter, feeling that it was a nice thing to consider theoretically, but they never seriously considered the starting of such service. However, every one of them came out of that out-patient department smiling happily, shaking their heads and forming into groups to discuss this wonderful miracle which had grown up overnight, its value and its success. Then they came around hunting for the superintendent, demanding that various other clinics be started at once, for all the various services. To each we stated that as soon as the need was demonstrated, we would furnish a schedule, but that they were in a far better position to determine this need than the hospital. A special meeting of the staff was called, which was fully attended, and the need of a complete out-patient department was thoroughly discussed. Every man told of the things he knew which demonstrated the need of such a service, and it was unanimously agreed that we should inaugurate such a service as soon as it could be arranged. A committee was appointed to confer with and assist the superintendent. The next morning was the second of our children's clinics, and twenty-one new cases were in attendance. And in addition, six returned from the week previous. We had a regular overflow meeting, our dietitian taking care of the feeding and undernourished cases and receiving advice from the attending physician, who, with his assistant, was literally swamped in the one small examination room.

One thing we had to do promptly was to set days for such other clinics, as we found cases which needed to be referred to the various services. We arbitrarily did this, telling the mothers to return to the surgical; the ear, nose and throat; the eye; the mental clinics, etc., on the day we then determined upon. After the clinic, the chief came to the superintendent and demanded more examination rooms. He was emphatic in his statement that another examination room must be had, at once. Then we sat down and made up examination cards for each service and assigned our staff to begin the first week in July. We then purchased sufficient beaver board and put in a partition of this material with a door dividing the large waiting room in half and making one portion another examining room.

On the following Saturday, the three dailies carried large headline stories about the various clinics, including the time, etc. On Monday, we started with the following schedule: 9 a. m., sick children, and at the same hour, nutrition clinics; 11 a. m., psychopathic; Tuesday, 9 a. m., eye, and at the same hour, prenatal clinics; Wednesday, 9 a. m., medical; Thursday, 9 a. m., ear, nose and throat; Friday, 9 a. m., surgical; Tuesday evening, 7 p. m., venereal.

Our staff was organized so that each man had his part. Where there were two men on a service, one was assigned out-patient department and one house for six months and then switched for the following six months.

The three local welfare organizations have cooperated splendidly. The Public Welfare Association investigates every case, as to its social condition. The visiting nurses and the Red Cross refer many cases. The visiting nurses also take one of our pupils into the follow-up service. Our laboratory and drug room are at the disposal of the clinics at all times. Minimum charges are made whenever possible.

While it has been our endeavor to make it clear that only the very poor are to receive the benefits of the out-patient department, there have, of course, been a number of cases attending the various clinics who were financially able to pay their family physician for examination and treatment. Sometimes this can be noted from the general dress and appearance of the patient or the relatives accompanying the patient, and sometimes the information is given quite frankly to the admitting clerk (and in these cases it is simply a misunderstanding on the part of the prospective patient as to what the department has been established for). In our community, as in most others, there is a lack of understanding, sympathy, or co-operation among various groups of practitioners, and those men, connected with other hospitals, deeply resented the fact that some of their patients were coming to our out-patient department and receiving advice and, where needed, treatment. We have tried to minimize these cases as follows: when the patients enter they are asked the following questions: name of father, name of mother, by whom employed, income, number in family, number of sick members of the family, and name of family physician. If this information indicates that the family may be in a position to pay for their services, a few words of advice regarding the patient is given and he is then

referred back to his family physician with a note from the attending clinical man as to what he may have discovered or may have said.

All other cases are given a thorough examination, treatments are ordered and the patient is asked to return on the next clinic day. If it is a first visit, the name, address, and information given are transcribed on a sheet which includes numerous other questions dealing with the social or financial condition of the family, and these are sent to the local public welfare organization, who make the entire investigation for the hospital and send the reports back in order that we may have them at the next visit of the patient, or that we may know what course to pursue if the patient has had to come into the hospital immediately. In this manner we are minimizing the amount of care given to people in a position to pay and it has done much to eliminate the criticism from the family physicians or from other groups of men. That too much consideration should not be given to these criticisms is evidenced by the fact (and it has been our pleasure to point out to some of our critics specific cases) that patients come to us who have been under the care of some other physician at some previous time and we find the patient in a serious condition or needing immediate medical relief so that we are able to say, "If this is the kind of service you have been giving your patients you ought not to say very much about it because it reflects upon your practice of medicine."

In the follow-up of these cases we are using one of our pupil nurses in conjunction with the Visiting Nurses' Association.

We have not attempted to form any pay clinics, nor do I think we will for the present. We are keeping very clearly in mind the fact that in a small community such as ours, new ventures like this are largely educational, and that, if they are to ever grow into the big things they ought to be they must develop slowly. Also in order to secure the best results the demand for improvement in the operation of the idea must come from the outside. In this connection, I wish to emphasize the fact that we all in our hospital realize that there are many imperfections in the way in which we are operating this department and that there are many improvements to be made. We realize that the waiting room is very imperfect, that the examination rooms are not equipped as they should be, that they are crowded, that there should be pay clinics, that there should be better follow-up service, that the work



might be more thoroughly done, but I am strongly of the opinion that no person or group of persons can get the vision of a big idea, a big plan, or a big development and sit down and plan the operation of this idea or development in detail, then put in all the machinery, start it off, and have it work out as planned. But I do believe most thoroughly that we ought to take our idea or our development plan, put it into operation as quickly and as well as possible, and then iron out the wrinkles afterward, and improve it as we go along. I believe that the service this little out-patient department has rendered the community during its three months of operation, the good it has accomplished, and I might add the lives that have been saved, fully justifies its existence and far outweighs its many small imperfections.

It may be of interest to you to know that in addition to the people from the city who have attended the clinics, we have had a considerable number of patients from the rural communities; farmers and residents from small towns are coming in here or being brought here by the rural physicians.

You will observe that there has been little or no expense attached to our out-patient department thus far, but with the continued growth of the work the matter of financing it must be given consideration. As we develop our other hospital facilities, it will be necessary to use the present rooms for other purposes and in doing that we find ourselves in the fortunate position of having a building on the grounds facing a side street, in which are housed our maids and porters. The ground floor of this building could be made into a really first class out-patient department, but when this is done there will be additional costs in higher wages to the help and in maintaining the building. And in addition to this, as our hospital fills up with patients, there will be the additional cost in maintaining the increased amount of charity work which is now taken care of with our present overhead, with no additional expense. The method we are most seriously considering is that of either going before the public with a statement of exactly what our free children's department and our out-patient department are costing us, and asking for contributions to support this work, or on the other hand putting this part of our hospital service into the federated charities. We feel that support of such special work will be far more generous and spontaneous than if we should ask the public to support the hospital as a whole.



CHAIRMAN RANSOM: Before announcing the next speaker, who is going to speak very briefly on some rural out-patient problems and their solution, I wish to make one or two announcements. First I would like to invite all of you and have you invite your friends to the demonstration clinic in the main exhibition hall of equipment and organization of out-patient service for patients suffering from venereal disease. We are very fortunate in having as a member of the committee, Dr. Thomson of the American Social Hygiene Association, who is here specifically for the purpose of assisting any hospital superintendent or dispensary superintendent or anyone else who may be interested in the establishment and development and operation of clinics for the treatment of venereal disease. Immediately following this session which will close rather promptly at 11:30 there will be a motion picture in the motion picture hall, a picture showing the routing of patients through a clinic. Dr. Thomson, whom I have already mentioned as director of the medical department of the American Social Hygiene Association and a member of the out-patient committee of this Association, will very briefly tell you something of the community clinic, which is a rural asset.

DR. A. N. THOMSON, of the American Social Hygiene Association, New York City: In the rural community the dispensary is a very serious problem, particularly to those of us who are interested in the control of venereal disease. The State of Alabama had half a dozen clinics in the large cities, which they called free dispensaries. They were the usual type; that is, they in no way met their problem, for the rural district. The State of Alabama subsequently established so-called cooperative clinics, of which they now have over 70, which simplified their problem very much. Other states have taken on the same idea and worked it out. The cooperative clinic linked up with the health officer, linked up with the health center should give the solution. The cooperative clinic consists merely of one doctor who is selected by the local health authorities and the local medical profession in conference, which decides that Dr. Smith, of such and such a town, which may or may not be a county seat, will handle the indigent or those unable to obtain private specialist's services individually. If he is indigent, the community assumes the responsibility for the patient's care; if unable to pay full fees, the doctor is permitted to charge a fixed fee. The health department supplies the physician with

drugs and equipment, and the physician agrees to charge, in a venereal disease case not more than \$2.00 per visit. The equipment and supplies consist of instruction, the ordinary number of syringes for salvarsan for the treatment of gonorrhea, needles, silk and the simple stuff, also the drugs necessary for the treatment. In return, the doctor agrees to charge not more than the fee of \$2.00, to take postgraduate work from time to time in one of the larger clinics, to follow the routine as suggested by the health department along public health and social lines in addition to the medical line of treatment, to thoroughly educate his patients, and to promptly report them. The scheme has apparently worked. This is merely given as an idea that may be of interest to the small hospital that has possibly just the one room. Such a hospital may perhaps be able to utilize the so-called cooperative-clinic idea, which will take care of our rural problem where the need at least in venereal disease work, is not sufficient for the establishment of a full size dispensary.

The meeting then adjourned.

## SECTION ON HOSPITAL CONSTRUCTION

September 14, 1921, 10.00 A. M.

West Baden, Indiana.

This session was called to order by the Chairman, George O'Hanlon, M.D., Superintendent, Bellevue Hospital, New York City.

THE CHAIRMAN: The section will please come to order. For your information, I will say that the members of the Committee of the Section on Construction held two meetings during the year to determine on the program to be presented at this conference. At previous conferences we have had one or more set papers on some subject of common interest. We have found, however, after the meetings, that these papers, while they are interesting, did not answer all the questions that some in attendance brought with them that they would like to have settled; so we decided to make this purely a round table gathering, and hope that those of you who have construction problems of any kind—that does not mean necessarily the building of a new hospital or a nurse's home or a power plant, but anything that has to do with the construction of a hospital or your plant. We would like to have these presented and perhaps some one here can

help you; if not, I am sure, by the asking of questions, you will have contributed something to the meeting.

I hope all of you will feel that this is your meeting and you are perfectly free to get up and say anything, or if you desire ask any questions that may occur to you.

A number of questions have been submitted. The first one to be presented is, "the cost per cubic foot for construction at the present time." Now, that, of course, is very general—whether you are building a garage, a hospital or a nurse's home. As you all know, to attempt any construction in the last three or four years, the cost has been almost prohibitive. We are finding in the east that there is a very decided reduction in the cost. We have recently opened bids for an addition to the hospital and find that prices for practically everything except unskilled labor has gone down very decidedly. Skilled labor, I think, in and about New York, is going down. Whether it is the same throughout the United States, of course I do not know. Mr. Bartine, your Secretary, tells me that the purport of his question was the cost of a completed hospital, not any separate or individual building. I do not know whether Mr. Stevens or Mr. Smith, can contribute anything upon this question, just to start the subject.

MR. STEVENS: Mr. Chairman, one of the first questions asked by a Building Committee or the Trustees, when new plans are being considered, is the cost of the buildings. This is one of the hardest questions an architect has to answer today. In pre-war days one could estimate with some degree of accuracy, but during the last few years we have been unable to do so. As a matter of comparison as to the cost today and the cost of a year or so ago, I will name one concrete example. On one hospital we had actual bids one and a half years ago, covering a complete building, which bids were rejected on account of the high prices. Four months ago new bids were taken on the same building and contracts let for a sum from thirty to thirty-five per cent lower than the original bids. This will give you an idea in this case of the reduction made in labor and material within a year.

The question of the cost per cubic foot is the most difficult one to answer. The only sure way to ascertain the cost is to have a definite bid made on the complete hospital at the time.

THE CHAIRMAN: I think the only question in the mind

of the party who asked the question was the actual cost of construction; nothing to do with equipment.

MR. STEVENS: Taking the cost of a few institutions upon which I have had estimates quite recently and putting it on a cubic foot basis is about the only way I can give you any idea of the comparative cost. For general fireproof construction, the cost as shown in recent estimates has run from fifty-five to sixty cents a cubic foot. As a basis of comparison, figures taken some ten years ago on hospitals of the better class of building in the City of New York showed a cost of thirty cents per cubic foot. This shows that last year prices were simply double what they were ten years ago. Now, that is my own experience, but during the past year there seems to have been a decided drop of perhaps from thirty to forty per cent.

On this basis, the cost per bed—which varies, of course, with the size of the hospital—in a hundred-bed hospital would work out from three thousand dollars per bed ten years ago, to five or six or seven thousand dollars per bed today. This, perhaps, is as near as I could give any idea of the cost of construction, but there has been a decided drop in the last six months.

THE CHAIRMAN: I would like to ask what section of the country those new prices would reach, whether the east or west.

MR. STEVENS: The particular hospital which I had in mind, where prices were taken a year ago and again four months ago, is in Brandon, Manitoba. I think the prices have gone somewhat lower in the east—in New England.

MR. CHAPMAN: Is it not true, Mr. Chairman, that prices in small communities have dropped to a larger degree than in larger communities? Would you say it was proper to say thirty-five or forty per cent. as compared with six months ago?

MR. STEVENS: I have no definite proposition to state. Estimates on the same thing within a year have shown in some of our western sections a greater reduction than in eastern sections of our country.

MR. TEST: Mr. Chairman, I think we must have several cases in order to arrive at any intelligent conclusion. One swallow does not make a summer. I think it might be interesting to know an experience we had in Philadelphia. To be sure it was a special construction of some outdoor porches to a clinic building. In 1916, five years ago, estimates were given for these porches of \$21,300.

Eight months ago estimates were again secured and the estimates were about three times—a little more than three times—about sixty-five thousand dollars—for the same construction. We were led to believe there has been a twenty-five or thirty per cent reduction in the cost of construction; so two weeks ago we had another estimate, and the last estimate was fifty-three thousand dollars for the same thing, that we had estimates of \$21,000 five years ago, and only eight per cent reduction on the estimates we got eighteen months ago.

DR. WALTER H. CONLEY: Mr. Chairman, about five years ago, we asked for estimates on an addition to the Metropolitan Hospital, New York City, and at that time we were informed that the total cost would be \$30,000. During the year, estimates were asked, and it was found that it would cost about \$66,000 to build. Two years ago, bids were again asked and the price was \$93,000. In July of this year, bids were opened and the contract awarded at \$73,000. This shows a decrease in two years of about 18%. I believe that the decrease in the cost of construction averages about 20%.

A MEMBER: Mr. Chairman, in attempting to build a surgical hospital in Cincinnati of one hundred beds, we had estimates two years ago, and they ran about \$4,500 a bed. I have tentative estimates now, which are not very accurate I must admit, at \$4,000 a bed, which would indicate a reduction of twenty per cent. I think that corroborates the figures of the gentleman who spoke a moment ago.

MR. RICHARD SCHMIDT, Archt: Mr. Chairman, my firm has been receiving contractors' bids on a number of hospitals, on one of these we had received proposals three years ago and again about eighteen months ago, and recently we let the contract. Eighteen months ago the figures were around 72 cents a cubic foot. The work was let last month for sixty cents, without altering the plans or specifications. In the last six weeks there has been a considerable reduction in labor in many centers, principally in the Middle West. Inasmuch as these buildings are located there and I believe it is possible to obtain proposals based on about fifty-five cents a cubic foot, in this part of the country, however, I think that is as low as any one could possibly estimate. Obviously, fifty-five cents a cubic foot does not mean much taken by itself, because the cubic footage varies considerably per patient in hospitals. The cubic footage per patient is sometimes as low as four

thousand, but I know of private hospitals which have 12,000 and 13,000 cubic feet per patient.

Replying to the question of Mr. Chapman, prices in small communities are not lower than in large cities; that is true, I find in the west, but that is due more to the fact that small cities do not have building ordinances than to labor or material unit costs. The builders are not held to extraordinary thicknesses of walls or special foundations or to use fireproof windows and fireproof doors, as they are in the big centers. Of course, the hazards in the small places are not as bad as in the big cities. That makes it possible to build buildings cheaper in small communities, but the cost of similar buildings would be the same. Facilities for obtaining material, transporting it and the obtaining of skilled labor are so much better in large centers than in small communities, that while they pay more for labor, the whole cost should be, if anything, less in a big city than in a small town.

THE CHAIRMAN: This question that has just been submitted for solution, and the matter under discussion, make it interesting to learn how many hospitals represented contemplate new buildings.

(The Chair reported that the show of hands indicated about forty contemplated new hospital buildings inside of a year.)

MR. E. J. HOCKADAY, Superintendent West Suburban Hospital, Oak Park, Ill., a suburb of Chicago: We are building a ninety bed addition to our hospital, construction was begun September 1. The building was planned about two years ago; last fall we took figures and they were so high we decided to wait. We took figures again this fall and found them about thirty-five per cent less than a year ago which saved us about one hundred thousand dollars. The building is reinforced concrete construction and the cost per cubic foot is about fifty cents and the cost per bed is about twenty-five hundred dollars. The bed cost is low on account of it being an addition to our present hospital which contains all auxiliary and service rooms.

REV. F. O. HANSON, Iowa Lutheran Hospital of Des Moines, Iowa: Mr. Chairman, in Des Moines, Iowa, we are building right now a structure—a new nurse's home. This building is five stories high, with a basement. There is a swimming pool in the basement; we have lecture rooms and study rooms, also individual rooms for the nurses. The building is fireproof, made of brick and tile and re-



inforced concrete, and very nicely arranged. This building is going to cost us less than two hundred thousand dollars. I cannot give the exact dimensions just now, but it will figure less than forty cents a cubic foot. There is room for 150 nurses in the building. Two floors will temporarily be used for hospital purposes.

A MEMBER: What is the cost of the contract?

MR. HANSON: It is not let on contract; it is being built on a percentage basis.

MR. GEORGE STOKER, of Winnipeg: Mr. Chairman, we have just completed the erection of a nurse's home of 187 beds. It has all the features that the last speaker spoke about. It cost \$389,000. It is of fireproof construction, has four floors and basement, and three of the floors are equipped with individual rooms. This same building we tried to erect in 1914, that was when the war broke out—and the tenders for it then were \$175,000. It has cost now \$389,000.

As to the cost per cubic foot, it has averaged at those peak prices, forty-five cents. Of course the type of construction has a lot to do with the cost per cubic foot. The cubic foot dimensions of our building include verandas, and as there are outside sleeping accommodations for each of those 187 employees who live in the building, that veranda construction, of course, is averaged in the cost of the building, and is included in its cubic measurement.

THE CHAIRMAN: Those of us who are conducting our hospitals in old—very old and worn out buildings—have difficult problems to meet and solve. Perhaps two months ago, one morning I heard a terrific noise and a few minutes later it was reported that the plaster over a bed in one of the wards, in use for over 100 years, had fallen. Since coming here I find that Mr. Chapman of Cleveland is having the same trouble—the plaster in his comparatively new hospital has been coming down. He told me a little of his trouble, and I am sure it is a matter of interest, because the same thing may happen to some one here, and the information that you get from Mr. Chapman might enable you to avoid some of the difficulties that he has been meeting. Mr. Chapman, will you tell us your plaster difficulties?

MR. CHAPMAN: Mr. Chairman, ladies and gentlemen, the same thing may happen to some of you, so I shall try to give you an account of the difficulties we have had in our building. Our building was planned by presumably one of the best groups of architects in the country. I have

never known of a building that was watched closer in its construction. I have never known of a building where more time was put upon the specifications by men who knew their business. The Chairman of our Building Committee was a man who had had a vast amount of experience in actual building operations. We had supplemental advice from some very large material men and very large material interests in the city, and I want to assure you that there was really intelligence put into the specifications and in the planning of that building. In the first four and a half years we had the usual incidental plaster trouble that might be expected in a building of that size. In June of this year we had plaster trouble in three rooms; but inside of three days from that time we had 27 ceilings come down. In a period of forty days, probably sixty per cent of the plaster of the building fell off; so we are making a good job by taking it all off. We have had six chemists and about fifteen practical plasterers trying to tell us what the trouble is. Their reports vary from one to seventeen pages, and it is the finest combination of nothing said that I have ever seen. The material is fine and the workmanship is fine, but the fact is that the plaster is coming off. By exercising personal influence, I had samples of our plaster examined by a laboratory which does not do commercial work. I wanted to be sure that we were getting an unbiased point of view and here is the most logical explanation I can offer out of my extreme ignorance as a chemist.

They maintained that in the hydrating process there was too large a percentage of magnesium salt; that by the infiltration of water a chemical action is brought about, causing defect. But I ask, "What would keep that plaster up for six years and then have it all come down at once?"

We have taken the Government records of the weather during the period the plaster was on. We had at no time in the building any salamanders. The work was done in the fall before the frost.

Another question which I know you will ask is about the paint. There was no painting done until seven months afterwards. The plasterers had put on three separate, distinct coats. It was the ordinary plaster. As near as I could figure it out the answer is—if you get small particles of impurities in the lime it will do the damage.

THE CHAIRMAN: The next question is, "What is the best method of disposing of waste—clean paper, old flowers, refuse gauze, kitchen waste, tin cans, and so

forth?" I presume the question is whether we should provide incinerators and hospital furnaces.

A MEMBER: I have asked that question every year that I have been here. We are in the midst of writing specifications for our new building. The question of whether we should put right in the building an incinerator plant with a flue extending up through the building and openings into the flue on each floor, the chimney being the flue. That is the question. Is that practical? Who has had experience as to what is the best way to put it in? The question is whether to install the incinerating plant in the building or have it in a separate building.

MR. RICHARD SCHMIDT: Mr. Chairman, the Kerner incinerator is a very practical device for apartment houses, but I doubt if it would prove so in a hospital. I would prefer the method used in hotels, i.e., passing all scraps and scrapings over a long table with low sides which allow the spreading out of this material and the recovery of silverware or other articles, I know the salvage to amount to hundreds of dollars per month in large hotels.

A MEMBER: I have a little stock in one of the best incinerating plants in the country and I would not have them in my hospital if they would give them to me. We have had in the Pennsylvania Hospital for twenty-five years an incinerating plant that works splendidly. I used to have a small plant in my home, but I could not make money enough to pay for the waste that would result from it.

THE CHAIRMAN: We have had the same experience at the Bellevue Hospital. An incinerator was installed in the kitchen or wards in one of the buildings. We used it about six months. The difficulty was in keeping anything in the building. Dishes, instruments and articles of all kinds were found in the incinerators. The street cleaning department now removes certain kinds of refuse for us. The waste we have to dispose of ourselves. We are using in connection with the power plant incinerators or furnaces. The objection to this is that there is a constant soot coming from the top of the smokestack, which settles down on the roofs and sometimes drifts into the building. For that reason it is very objectionable. Before any of our refuse gets in the incinerator, we have it inspected. I am sure we save the salary of the inspector many times over every week.

MR. CLARK: I was very much interested in this thing. I have lately seen two installations. In both of these instances, the superintendents were enthusiastic about it. They said they had no waste; they had no waste because they gave nothing out upon any floor until the articles that had been given out were returned for inspection. If there was nothing for inspection, then the cost was divided among the nurses on the floor.

DR. FAXON, of Massachusetts: I would like to ask a supplemental question to this one, namely, has any one had any experience in reclamations of any of these materials discussed here? Can any of the material be disposed of at a profit? We are putting in a general incinerator and we hope to work out something along that line. I would like to know whether any one has had any experience, making it a success, or whether it must be considered wholly as waste.

DR. L. A. SEXTON, Supt. Hartford Hospital, Hartford, Conn.: Mr. Chairman, our garbage and papers are all kept separate. The papers and magazines are baled and sold, the garbage is collected in a concrete vat and sold for \$200 per year.

DR. WALTER H. CONLEY: Mr. Chairman, I would like to say that the City of New York is experimenting at the present time trying to find a method of disposing of garbage. An attempt was made to press the garbage into bricketts after it had been ground. It was impossible to do this on account of the quantity of water contained in the garbage, and no way was found to express the water and form the brickett. This scheme was abandoned. At the present time they are trying another method to separate the water and press the garbage into bricketts. Up to the present time, this other process has not been a success. The City of New York has expended about \$30,000 or \$40,000 upon machines, under the direction of one of the city engineers. We hope that in the near future a method will be found to treat garbage in this manner.

THE CHAIRMAN: Anyone else want to contribute anything?

DR. W. L. BABCOCK, Supt. The Grace Hospital, Detroit: Incinerator plants, constructed for hospitals, should be provided with hot water coils, in order to utilize heat elements otherwise wasted. The burning of waste can be made, to a varying degree, an earning instead of an ex-

pense, and the incinerator coils thus utilized is an auxiliary to the hot water system.

MISS ROSE ZIMMERN VAN VORT, of Richmond, Va.: The objection to the incinerator, just referred to, especially if it is situated in the basement of a hospital, is that there is a peculiar pinkish smoke, when garbage is being burned at night, which looks as if the hospital were afire. We have had as many as one-half dozen people coming in to the hospital in possibly 10 or 15 minutes saying the roof of the hospital was afire.

THE CHAIRMAN: The next question: "Can basements be omitted and hospital built directly upon the ground, if floor is waterproofed, with heating plant separate?"

MR. RICHARD SCHMIDT: If you build a hospital directly on the ground and I take it that you propose to place patients on the ground floor, you must be careful to select a location which is well drained and has other proper soil conditions.

The arrangement or planning should be such that the service pipes which are usually on a basement ceiling will not be visible in the public or other better rooms. They should be placed on the ceiling of the ground story because if you place them in special conduits under the floor they will cost almost as much as a basement.

Certain arrangements will permit of doing this; in others it is not practical.

The Alexian Brothers Hospital in Chicago and St. Anne's Chicago have no basements. The ground floor is only one step above the surrounding grade.

It seems a convenient and satisfactory arrangement. From the point of appearance they are as satisfactory as if they had basements. Visitors or patients rooms are not encumbered with service pipes and there are no trenches or conduits.

THE CHAIRMAN: Anyone else have any experience?

MR. CHAPMAN: Our institution has no basement.

THE CHAIRMAN: We have one hospital on the river front, not built on the ground, supposed to have a waterproof basement. Twice, in spite of the waterproofing, we have had water in the basement. I think the same condition might exist if you had a waterproof floor of a building on the ground. If conditions are right you will not have trouble; if they are wrong, you will.

MR. STEVENS: I have found from my own experience that it is really economical to place a pipe space below the low floor. This pipe space need not necessarily be of

**finished construction.** It can be on the ground. The pipes can be hung to the under side of the floor and the place made absolutely hygienic without any trouble.

**DR. WALTER H. CONLEY:** Do you mean a pipe gallery large enough for a man to work in?

**MR. STEVENS:** Answering the doctor's question, I would say we would need head room in the center, giving room enough for the pipe fitters to work at the extremities of the space.

**THE CHAIRMAN:** There is one question here that does not directly bear upon construction, but it was suggested by something which was said,—“What per cent of hospitals work over their gauze, and with what results?”

**THE CHAIRMAN:** May I ask those that use over any part of the gauze in their hospital to kindly raise their hands?

(Forty hands were raised—a majority of those present.)

**THE CHAIRMAN:** We have three questions here relating to floors. Perhaps you know there is a committee working on this problem of hospital floors at the present time. Mr. Chapman is chairman of the committee, and while he is on the program to submit his report at another session, I will ask him to speak here.

“What materials are best to be used in putting in floors in hospital rooms?”

“I would like to have the opinions about the kind of flooring in wards.”

“Treatment and care of cork and tile floors.”

**MR. CHAPMAN:** Mr. Chairman, the subject of hospital floors, in my mind, is one of the most important things that has to be considered. When I was approached on the subject of this report, I could not visualize how it could be done. I believe any study of this kind must of necessity be my own opinion or somebody else's opinion, and there is nothing absolute in it. There is, of course, the possibility of very elaborate laboratory tests as to abrasiveness, durability, and so on and so forth of various materials, but after all these laboratory tests must of necessity be made of material under ideal conditions and not under actual working conditions, and could not be an indication of the actual conditions that a superintendent will be confronted with in the installation of any given material, and, after all, that is the only thing that is of any value.

I want to hereby acknowledge with thanks the impressions that I have gotten from a great many members of



the association, superintendents, architects and others, in giving suggestions as to how this questionnaire should be worded. This is about the eleventh questionnaire that I have drawn up, and it has not been sent out yet. I have divided floors into thirteen classifications, first private rooms; next, wards; next, service rooms, laundry rooms, operating rooms, out-patient, department treatment and out-patient rooms, kitchen, offices and laundries, and then divided the qualifications of each individual floor as to its appearance and sanitation and durability and maintenance and costliness, and so forth. Then I have listed all the known types of flooring that I have heard of under groups and asked for information on the various floors. I have asked for an expression of your opinion as to your first selection, in every one of these thirteen different activities. I have asked for the expression of opinion as to whether or not repairs can be made equal to the original installation; what are the characteristics of the defects, and the cost and a lot of other things. I can only have a good report by having the cooperation of every member of the association interested in hospital floors.

THE CHAIRMAN: The next question, "Please ask for opinions about a central serving room from which all meals, wards and private rooms should be served, or are the individual serving rooms preferable?"

MR. CHAPMAN: As to serving rooms, I presume our institution is one of the first institutions to attempt to adopt the practice of a central serving room. I would say it depends upon the type of food carrier used. If you have the proper food carrier, it will work out more economically than individual serving rooms. If you have not the proper food carriers, you will have improper food service to the patient.

DR. JOHN M. PETERS: I would like to ask, what is the proper type of food carrier?

MR. CHAPMAN: We have gotten away entirely from the unsatisfactory steam table and we are serving direct from the stove to the plate of the patient, handling food in three handlings, from the stove to the patient. We are getting soups to the private rooms so hot that they burn themselves with it. We use the carrier manufactured in Toledo. There is no question but what this is an evolution in hospital service—an insulated carrier.

THE CHAIRMAN: The next question, "In building a new children's hospital, is it advisable to have stalls or cubicles in admission wards?" Speaking from my own experi-

ence, we have a rather large children's service. The children are kept under observation in separate wards for at least 72 hours. We have in that ward a series of cubicles. If a child does not develop or show signs of development of any condition that is objectionable, at the end of 72 hours, they are transferred to the regular wards for children. Now, if they do, they are either kept in the cubicles or sent to the proper hospital. Answering the question, I suppose you would have to know the type of children's hospital, whether you take contagious disease or not.

DR. D. L. RICHARDSON, Supt. City Hospital, Providence, R. I.: Mr. Chairman, I believe a children's hospital should be built with small rooms, whether we use cubicles or separate rooms. I rather think separate rooms would not cost much more, but if you alter an old hospital, I believe cubicles would be more feasible. Every new case which is admitted to a children's hospital is potentially infectious, so that you would have to guard against errors in diagnosis, because it is impossible to make correct diagnosis on admission. All new patients should be put in small units, and if you make a mistake in diagnosis of the patient in the incubation period of a certain disease, the damage is only slight, carrying out the same technique that you would in a big contagious hospital.

DR. HOWLAND: Could you tell us how long to keep the case in isolation after admission?

DR. D. L. RICHARDSON: One week isolation is a great aid. Now, this is not the incubation period of many of the contagious diseases, like whooping cough and measles, but it does a great deal of good. What I think is perhaps of more value and saves a great deal of trouble in moving the patients from one ward to another, is to divide each ward into an acute section and convalescent section, and put all new cases through a single room preferably, or cubicles, when they first come in, for an observation period of one week, and then if nothing develops to transfer them into the convalescent section of that particular ward. It saves a great deal of trouble in moving from one ward to another.

THE CHAIRMAN: We will pass on to the next question: "How many hospitals here represented are equipped with overhead sprinkler piping for protection against fire?" I suppose the purpose of the question is to find out whether sprinkling devices are in general use—how many

hospitals are equipped with overhead sprinkler piping for protection against fire?

DR. JOHN M. PETERS: Mr. Chairman, personally I think this is a very important question. If the members here would look into the sprinkler system, I think they will find they can have a sprinkler system installed and save the cost of the sprinkler system in their insurance in a few years. We have had experience. We have had two fires put out by sprinklers. Nobody knew about the fires until the water ran down through. I think you can get contracts from the sprinkler companies that will show quite a saving, when you consider the item of insurance.

DR. C. W. GOODWIN, Superintendent, The Staten Island Hospital, Tompkinsville, N. Y.: I think in a building where the fire hazards are very great, this is a very important question. I do not know of any municipality which requires a hospital to put in a sprinkler system. If you put it in, you put it in because you believe it is demanded or needed. In our institution we employed a fire inspector from a company in Philadelphia to go over the whole plant. He recommended that we put in a sprinkler system in the basement and in the main building housing the private patients. That was put in three years ago and I understand that our insurance rate has been reduced thereby.

DR. L. A. SEXTON, Superintendent, Hartford Hospital, Hartford, Conn.: Mr. Chairman, three years ago we began the consideration of a sprinkler system for our hospital. We got bids from three concerns at that time, the lowest of which was \$21,000. This was more than we could afford then. Bids were asked for a year ago and the lowest bid was \$12,000 on the same installation. These bids were reopened three weeks ago and the lowest bid was \$8,000. The reduction in the cost of our insurance by having this system will pay for the installation in about eight years.

MR. CLARK: I would like to know if somebody can tell us what the effect is upon the patients, to know that a sprinkler system is installed in a hospital?

THE CHAIRMAN: Can anyone answer that question?

MR. J. D. BURGE, Louisville, Ky.: Mr. Chairman, I cannot answer that question direct, but I am a member of a Board of Trustees that has lately signed a contract to put in the sprinkler system for the Norton Infirmary, Louisville, Kentucky. I was asked to inspect a building that had a sprinkler system and while making this in-

spection, it so happened that a fire started and was put out by the sprinkler system. Our Board considered this thing for some time; they always were divided on account of the cost, but finally it was contracted for. I want to say that our Board of Trustees believes unanimously that the patients will sleep better and feel a whole lot safer if they know that there is a sprinkler system in the building. That is the reason our Board has expended the money. I am anxious to learn how many hospitals here represented are equipped with sprinkler systems. I would like to have a show of hands to see how many hospitals here represented have a sprinkler equipment throughout the entire building, nurse's home included.

THE CHAIRMAN: About ten years ago we installed a fire protection system in one of the buildings of the Bellevue Hospital. During this time we have had two or three small fires that were put out by reason of having the sprinkler system. Just how serious they might have been, of course I cannot say. We first discovered a fire by the water coming down. Now, I would like to ask a show of hands of those who have sprinkler systems or parts of sprinkler systems in their plant.

(There was a showing of hands, and ten responded.)

A MEMBER: Mr. Chairman, I believe if a structure is not fireproof, there should be a sprinkler in the basement and in the garret. I do not think they should be in the private rooms. They are ugly and I do not believe it would have a beneficial effect upon the patient. They would be watching that thing all the time. I do not think it ought to be put in the individual rooms.

MR. ASA BACON: We are negotiating with a sprinkler concern to put sprinklers in our store rooms, basement, carpenter shop and the paint shop. I think the carpenter shop and the paint shop are the most important places to install a sprinkler system.

THE CHAIRMAN: I have one more question: "May we discuss building of operating rooms with and without anaesthetizing room?" Is there anybody building a hospital or operating room with or without an anaesthetizing room? We shall be glad to hear from him.

MR. CLARK: We are just planning our new operating rooms and are providing for a separate anaesthetizing room, entered from a corridor, passed through, not directly, but at right angles to our operating room.

THE CHAIRMAN: I will be glad to hear from others.

DR. HOWLAND: I am rather surprised at that question. It does not seem possible to imagine a set of operating rooms without, at least, one anaesthetizing room. Patients going for operations should have as few disagreeable impressions as possible, and it certainly cannot be pleasant, may even be harmful, for a patient to be carried in a conscious condition into an operating room within sight and hearing of the preparations for an operation.

MR. BACON: I take issue with Dr. Howland here, because we have got to consider the small community hospital, and I know of one that gets along very well without an anaesthetizing room because of the size of the institution. The patient is put to sleep in his own room and then taken to the operating room.

DR. B. A. WILKES, of St. Louis: I do not approve of an anaesthetic room. There is too much time lost in transferring the patient from one room to another and from one table to another after the patient is under the anaesthetic.

I believe in conserving every minute possible from the time the anaesthetic is given until the operation is completed. Loss of time sometimes leads to serious result on the part of the patient.

Thereupon this Session adjourned.

## GENERAL ROUND TABLE ON DEPARTMENTAL PROBLEMS

Session in Convention Hall,

West Baden, Indiana,

September 14, 1921, 2:00 P.M.

This session was called to order by Mr. Asa S. Bacon, Superintendent of the Presbyterian Hospital, Chicago, Illinois.

THE CHAIRMAN: As you all know, these round table sessions are informal and this feature of our session is for the purpose of bringing out questions in departmental problems. It does not matter whether your hospital is large or small, if you have an idea I would like to have you express it at this meeting, because many of the superintendents of small hospitals have very valuable messages for superintendents of large hospitals, and vice versa.

I have not troubled you this year by sending out questionnaires for this round table.

The first question, "Should all patients receive a careful examination upon entering the hospital?" is a very important one, because as the medical profession is being split up into so many specialties, unless the hospital sees to it that the patient has a thorough physical examination upon entering, many times he does not get it. It seems unfair to the patient, for instance, to be admitted for an infected gall bladder, to be operated upon possibly, and no attention given to the mouth, which may be a dangerous source of infection. How many of our records of patients show a thorough physical examination? Personally, I believe that every patient that enters the hospital should have such an examination so that they may know the full extent of their physical defects.

MR. J. M. SMITH, of the Hahnemann Hospital, Philadelphia: Mr. Chairman, I do not think it can be done on private patients, unless the doctor who has charge of the private patient does it, and you can not force him to do it, and the patient is seldom willing to have an interne examine him.

THE CHAIRMAN: Your internes do not make physical examinations?



MR. SMITH: Not of private patients, unless the doctor sending the patient gives his consent and provided it is agreeable to the patient.

A MEMBER: Mr. Chairman, our institution is called a semi-private hospital. Practically nearly all the patients are sent in by some physician or surgeon. The patient is examined, sent in and assigned to a room, and the full history of the case is made out by the attending physician. I am of the same opinion as the gentleman who just preceded me, that it would be simply out of the question to get an interne to make a history of that case providing the patient was unwilling. I do not see how you could force a patient to allow an interne, or even a nurse, to take a history of his case and make a record of it without the full cooperation of the patient.

MR. MAYS, Garfield Hospital, Washington, D. C.: Mr. Chairman, The Garfield Memorial Hospital is meeting the minimum standard of the American College of Surgeons, and I am proud to say we are rated by them as a class A hospital.

When my attention was first called to the standardization work by a representative of the American College of Surgeons, I made a careful study of the way and means of meeting such a standard, and upon my recommendation the Board of Directors passed a resolution directing the hospital staff and the superintendent to make and enforce such rules as found necessary to meet this standard. We at first experienced some difficulty in securing full cooperation with the visiting staff, but after a letter explaining why certain rules were made and enforced, and our desire to maintain a strictly first class hospital was sent to every doctor practicing in this hospital, the objections in most instances were overcome by this explanation.

The greatest difficulty was the securing of complete histories and physical examinations of private cases, because some of the visiting doctors objected to an interne securing this information. In each case when this objection was raised, we assured the doctor in attendance that it would be perfectly satisfactory for him to furnish the necessary information, the ones objecting soon found that it was distinctly to their advantage to be relieved of this detail, and are now very glad to have someone else attend to this for them.

It is not necessary for me to attempt to explain the many advantages of this effort to elevate the standard

of our hospital, but if you will pardon my taking the additional time, I will cite a concrete case which occurred during our first week's effort at standardization. About two days after the letter mentioned above was mailed, one of our visiting doctors came rushing in my office with a demand to know "since when an interne was allowed to take histories on his private cases?" Replying, I asked if he had received one of our letters. Upon the statement that he had not, I then explained in detail just what we were doing. After quite an argument he finally concluded the interview with this statement: "Well, it might be a good thing, but what I minded most was that my patient gave me the mischief, and wanted to know if such questions and examinations were necessary, why hadn't I made them a week before when she first called me in?" As to the real benefit to future patients of this particular doctor, I will leave it to you.

I would like to say in conclusion, that I believe this standardization program should receive the unqualified support of all hospitals, because I believe it to be a very important step toward the maximum, the goal of perfect service to the public, to which we all aspire, as hospitals.

DR. MACEachern: I think every case should be examined and a history taken. That is undoubtedly the principle that all should follow. The work of getting the history is the greatest trouble, and the rule which we have always made in our institution is that the senior interne or assistant interne should see the patient immediately on admission and find out all they can about the patient, in order to transmit to the doctor the information secured and perhaps get some orders for treatment. After this the interne can proceed with the history and other data necessary. I find that most of the cases have been seen by doctors before coming in, and have not had any trouble is respect to the point in question. The point is to keep after the doctor until he comes up and sees the patient. Now, sometimes a nurse can get information out of the doctor which others cannot, for instance, I know of a hospital where the nurse or record clerk can get records out of the doctor better than any other means, because they are persistent, polite, and especially when they have a good personality and good appearance—they will keep right after them until they get it.

A MEMBER: In my experience of twenty years, I have never heard of a patient objecting to an interne making a history and a physical examination. We do not include

the vaginal examination of course, but the general physical examination—the chest and extremities are always allowed, and it seems to me that if there is any difficulty about this, it is the fault of the staff in not instructing this interne and giving him the proper supervision. It is a very, very vital part of the hospital work to have good internes, and you cannot have good internes unless the staff management has an intimate relationship with them, which means giving them every possible opportunity for instruction and always keeping them under supervision.

THE CHAIRMAN: Along the same lines as the speaker. I have twenty-two internes. The internes make most of the physical examinations, but all examination of women is done with the assistance of a nurse; a nurse is always in attendance with the interne. I have been in the hospital for twenty-one years, and I cannot recall of a single objection by a patient to an interne's examination.

DR. MACEACHERN: I think the idea is that the case should be seen within a reasonable time after coming into the hospital, unless they can be confined to the observation section. I believe that every hospital should have such a section. Recently, through the keenness and competence of a well trained nurse, valuable history was obtained and careful observation was made which saved the hospital a good deal of trouble. A patient came from a lumber camp to the hospital himself. He said, "The men are all sick over there and I began to get sick so I came back." The nurse said, "What is the matter?" And he said "I have a fearful pain in my back and chills." Just at that moment she could not get an interne. Using her better judgment she confined that case to the observation section, because she knew that was one of the signs of Small Pox. Within twenty-four hours this developed into a severe case of Small Pox. An ordinary person might have diagnosed that as Lumbago. I would recommend that every case should be examined as soon after admission as possible, and when there is any doubt the patient should be confined to an observation ward where they could be detained till the diagnosis was thoroughly cleared up, especially if there is any suspicion about it whatever that it might be dangerous.

A MEMBER: Mr. Chairman, I know of an incident where a physical examination caused two operations to be stopped that otherwise would have been performed. It had the effect of eliminating a few doctors who would have done work that was below the standard. This procedure

gives the patient a feeling that the hospital is taking care of them, looking out for them, and is not alone taking the patient into the hospital and getting their money, but is interested in their proper care.

A MEMBER: I have had no experience with a private hospital history, but if the diagnoses of patients arriving at private hospitals is not any better than those cases which arise in the municipal institutions, who have gone through the average practitioner's hands, then I think all hospitals ought to insist upon a thorough physical examination being made of every patient, because every week a patient is rushed in for an emergency operation. It is true they have only had home treatment, but they have been seen by reasonably competent men. After the patient is examined, it is not always best to operate.

THE CHAIRMAN: We will take up the next question: "How can the hospital in the small community be made of greater service to the physician practicing in the rural districts?" I would like to have this question thoroughly discussed.

MR. CLARK, Denver, Colo.: Mr. Chairman, I think this question was very well answered last year by Dr. Sampson of Creston, Iowa, who gave us some excellent ideas upon what a Community Hospital has accomplished in Iowa. One thing he mentioned impressed me as of special worth and that was the sending of traveling clinics from the hospital to outlying districts. There is undoubtedly a great need for the development of the Community Hospital to serve large rural territories. Fifty million people of the United States live in small communities and many of these cannot be said to have hospital service.

MR. DAVIDSON: Mr. Chairman, we have a small hospital in a rural community—a town of seventy thousand; within a radius of twenty-five or thirty miles there are perhaps twenty-five smaller towns. The doctors practicing in those towns have no hospital connection, and in trying to work out just such a problem as this, and taking Dr. Sampson's idea as a standard, we are planning to form an associate staff for our hospital, composed of those men practicing in the country who desire hospital affiliation and who will come onto that associate staff under the standards adopted by our hospital. Our own staff then will hold clinics before those rural physicians, permitting them to bring their difficult or obscure cases into the hospital and to make use of all the diagnostic facilities we have. As the young men come into those

rural communities to practice, they will come into the hospital as assistants. They will be connected with a hospital, and they may have the assurance of full privileges of that hospital as soon as they have demonstrated their ability. I think this is a plan which will help get the young men into the rural communities, where there is such a scarcity of competent physicians today.

THE CHAIRMAN: We will take up the next question: "Should the superintendent of the nurses' school be under the superintendent of the hospital?"

MR. MAYS: Mr. Chairman, this question to me is a very important one because I believe it strikes at the very roots of a perfect organization, so vitally important to the success of the hospital.

A perfect hospital organization, in my opinion, is one which makes possible the rendition of perfect service to the patient. Such service can only be rendered by an organization which has a single authoritative head, one who is the final court of settlement in all disputes between either heads of the departments, or minor employees.

I believe all hospitals should be conducted on a business basis, which in my opinion, can easily be accomplished without the slightest interference with the proper professional care of the patient, whether it be that of the nurse, doctor, or both. In fact an institution so conducted is in a better condition to render perfect service throughout the hospital than one conducted along different lines.

Getting back to the question, if you will but consider that from the largest and most important business in the world, (that of the government of the United States), and on and on down the line of other business such as banks, large commercial corporations, railroads and stores, as well as universities, colleges and schools, down to the smallest organization formed to deal with the public, you will find them all planned and organized irrespective of size, with a single executive at the head whose final word is law so far as the personnel and the general policy of the organization is concerned, and I firmly believe, as stated before, that after all a hospital is a business proposition and should be conducted as such, and any effort to divide authority between the superintendent of the training school, and the superintendent of the hospital, would meet with complete failure, and the disrupting of the organization.

DR. M. WAHLSTROM: Mr. Chairman, this question is a very vital one. I think that when the question is only

that of a well established policy, the superintendent of nurses should have all the latitude she needs, but if new policies are to be introduced, this should be done either in consultation with the superintendent or with the Committee on Nursing. In our hospital we have a committee on nursing and every new project or every new policy inaugurated is taken up and discussed, and there, of course, the staff, the Board, the superintendent, and the superintendent of nurses are represented. At our staff meetings the superintendent of the hospital, as well as the superintendent of nurses are accorded the privilege to be present and the right to discuss matters with the staff members. This constituted one of the forums where matters are brought for consideration, before they go to the Board. Our superintendent of nurses decides the fitness or unfitness of a probationer to continue her training, but in cases of discipline, before she can suspend or expel a nurse, she will have to consult the superintendent of the hospital. Of course, a case can always be appealed to the board of managers, but we have only few such appeals. We believe in cooperation. The superintendent of the hospital will refer matters to the superintendent of nurses, and vice versa. Therefore I think, notwithstanding the fact that I know the nurses' associations are ignoring the superintendents of the hospitals, yet they will soon learn that the superintendent of the hospital is the one to whom the nursing problems will have to be finally referred.

THE CHAIRMAN: Have the ladies anything to say upon this subject? If not, we will pass on to the next question, "How to install a laboratory in a small hospital?" Will someone tell us how that can be done?

THE CHAIRMAN: The person who asked this question, I am sure feels he wants a laboratory and that it is a hospital in a small community and he is seeking information as to how he can install this laboratory in this small community.

A MEMBER: I should judge that the person who asked that question wants to know how it is possible to finance a laboratory in a small hospital. Our hospital happens to be a little above what is termed "a small hospital," but we charge a fee to every patient that comes into the hospital and remains 24 hours or more, and with that fee we finance the laboratory and have a little surplus besides.

MR. DAVIDSON: Dr. MacEachern has published a pamphlet, in which he expressed the opinion that every hospital should have a laboratory; he gives the cost of minimum



equipment and the method of operation. I believe there are a number of copies to be had and every person interested in establishing a laboratory should get one of these pamphlets, at the Registration booth. In the matter of equipment, I am taking issue with him, as I have just had the pleasure of installing a laboratory, and the worries incidental to such a procedure.

In our hospital, they had been talking for years about a laboratory, but felt that the cost would be prohibitive; the general impression being that it would necessitate the outlay of between three and four thousand dollars. After assuming the superintendency of the hospital, we quickly determined that we could not carry on without the laboratory. Upon writing to many of the larger houses, we secured prices which led us to believe that we could equip the laboratory for about \$1,500. A wealthy lady interested in the hospital stated that she would give funds for this equipment as a memorial to her father and mother. The next thing, of course, was to secure the services of a competent laboratory director. After writing to every medical school in the United States, we were fortunate in securing the services of a man who had been Assistant Professor of Pathology at the Northwestern University in Chicago.

The services of good pathologists are hard to obtain for the reasons, as stated by Dr. Mallory of Boston: "Hospitals have been paying such small compensations that medical men have not taken up this branch of the service, and it is quite necessary for us to re-adjust our conception of the value of laboratory work." To our pathologist, we paid a salary of \$3,500 a year and 50% of the net receipts from the laboratory would give him an income of approximately \$6,000 the first year. In order to finance the laboratory, we decided to increase our rates fifty cents a day on each bed, and give the patient all the laboratory work needed without further additional cost, and when bills were paid we arbitrarily deducted fifty cents per day and credited this sum to our laboratory account. In this manner, we are assured of a permanent laboratory income sufficient to finance the work and pay the pathologist at least a fair compensation for his services.

After employing our pathologist, he and I went to Chicago and purchased the entire equipment for the laboratory for \$1,588, including re-agents, glass ware, etc.

Two things should be emphasized. First: that a laboratory should be installed in every hospital and so equipped

as to care for all kinds of work. Second: that a competent graduate of medicine should be employed as pathologist, and this can be done if the hospital authorities will take the aggressive initiative to do so.

A MEMBER: Mr. Chairman, we have equipped a laboratory at an expense of about \$3,000. We felt that although we were a small hospital, there was nothing too good for us. We could not afford our own pathologist so we made an arrangement with one at Milwaukee and we pay him fifty dollars a month. He has the same arrangement with other hospitals, and he comes and does the work for us when he is called for. There are days when we have a good deal of work and there are days when we have none. We find this arrangement very satisfactory.

A MEMBER: About a year and a half ago we equipped a laboratory for a hospital of 65 beds at an expense of a little less than \$500, including supplies. We make a charge of \$5.00 for patients entering to support it.

THE CHAIRMAN: We will pass to the next question. I have been asked to put this question to the members present. "What is the sentiment of the members present as to encouraging autopsy work in their hospitals?" Those who believe in encouraging autopsy work will please indicate it by raising their hands.

(A majority of those present raised their hands.)

THE CHAIRMAN: I might add, for your information, that in our hospital autopsies average for the year around 65%, and every Saturday the pathologist has a meeting of the medical staff, including the internes, when a review is made of all the work during the week. This has been of very great benefit to our internes and our medical staff.

A MEMBER: How can this be encouraged in the hospital? I found it very difficult.

THE CHAIRMAN: So far as we are concerned, that work is done almost entirely by the pathologist. In those hospitals not fortunate enough to have a pathologist, many times this work has to be done through the personal effort of the superintendent. At times the pathologist fails and the superintendent succeeds. Many times the interne can get permission when the pathologist can not, but at no time is there any undue pressure brought upon the relatives of the deceased. It is all done in a kindly, considerate way and in a manner tending to show them the educational advantage—the benefit to other sick people. We will take up the next question.

A question that was handed me by a trustee of a hospital: "In accepting a position as superintendent, should the applicant sign a long term contract?" The reason for this question is this; since the war started, there has been more or less of an unrest among the superintendents of hospitals, as well as other people that have to work for a living, and there has been a great deal of shifting, many times to the detriment of the hospital. I think that this is a matter that we should consider very carefully, because in taking a position as superintendent of a hospital, if you look over the institutions throughout the country you will find that the most successful ones are those who have superintendents that have stuck to their place for a long term of years. They are superintendents that are well known in the community they serve. Their names are by-words for honor in that community, and when the hospital starts out to get money, the mere fact that the superintendent has been on the job for many years and has probably brought the hospital up to what it is, the people have confidence in him and are more likely to contribute their funds, while on the other hand, if that particular hospital has had several superintendents during a period of years, the community has not the confidence they should have. I would like to hear from some of the members in regard to this, because it is really an important subject to the trustees.

MR. CLARK, of Denver: Mr. Chairman, it seems to me you have covered the subject except for this one point—the superintendents themselves change about on short notice, and in doing so often do not get the most possible out of the position; they don't receive the credit which is due them for their good ideas and their plans do not have time to mature—to prove out.

MR. HILDRETH: I believe the best recommendation the heads of departments can have, is the fact that they have filled their former positions for a period of years. In my business career, before I became superintendent of a hospital, I always asked applicants for positions, regarding the length of time they had spent in former positions even though they had letters of recommendation. Any one can get letters of recommendation. Friends can always be found who will speak of the qualifications of applicants, but the period of service counts for more, and really determines the value of these persons for the positions.

THE CHAIRMAN: The next question, "What are the wages paid employees in laundries?" The wages in our

laundry run about \$65 a month. Has any one else got the rate of wages in laundries?

(Several members gave the amounts, which were as follows:)

\$13.50 a week

\$14.00 a week

\$45.00 a month, including maintenance.

The next question: "The handling of laundry, whether direct to the ward or to a central linen room—how best to check laundry waste as to destruction and loss?"

MRS. HYATT, of Minneapolis: We have a woman who takes charge of our laundry and we check every piece of linen. It is inspected and goes directly to the laundry before going back into service. I find it a very successful way.

THE CHAIRMAN: Can anyone else give us an idea as to how to handle laundry?

DR. MACEACHERN: We had a great deal of valuable linen in our laundry torn by one of the big washing machines. On examination of the machine we found the interior more or less filled with pins in grooves, which were responsible for much destruction. I consider the best thing is to have good laundry machinery and a foreman who knows his business. Notwithstanding all of our efforts and the fact that we have a central laundry room, there seems to be a shortage. We do not know what the cause is. However, the big loss comes from the staining of linen. Sometimes blood has been left on too long before soaking in water. It is important to have such linen washed out before the blood is allowed to set therein. That is usually done by the nurse, but we found that the nurse's time was too valuable and other help was secured to do it. The question of stains in the linen brings up a source of great loss because, in the sterilization of same through heat means that such a stain will be set in more firmly than ever.

A LADY: Is it customary to count the laundry as it goes out?

DR. MACEACHERN: We try to count it but cannot get the laundry count to tally with our own. We are putting through from twelve to fifteen thousand pieces a day, and the time taken in making a count and the expenses of so doing was too much for all the good it did and consequently we gave it up.

THE CHAIRMAN: The next question is, "How are ward visitors controlled in general hospitals?"

For the benefit of the person that asked this question I might say that in the last issue of the Modern Hospital, you will find an article in regard to the routing of visitors that might give you the information desired.

MISS KEITH: Mr. Chairman, we have had an interesting experience; at one time we had 19 visitors coming to one patient, one afternoon, and we thought it was time to do something. We did not have enough chairs for the people to sit down. In order to regulate it, we installed a card service. Each public ward patient with us is allowed two visitors in the afternoon and one in the evening. We have cards that we issue. We have two cards for each patient, and when those cards are given out, that patient has no more visitors. Visitors are asked to return those cards at close of visiting hour, which they do. This system we found was a great relief in the public wards, and the nurses asked us why they could not have it in the private rooms, but that meant even more help. We now have what we call a service bureau run by two people, who take turns at it, one in the morning and one in the afternoon. One of the functions of the service bureau is to give out cards for the visitors. In the private rooms patients are allowed two visitors at a time. When the visiting cards come back, then they may be given out again. We have tried it for about a year in the public ward service and only about three months in the private room service. We have no thought of discontinuing it.

MR. HILDRETH: Are most of the cards returned to the office by the visitors when they have completed the visits?

MISS KEITH: Yes, they are returned. While it was not popular at first, it is being well received now. The friendly people who return the cards often say, "I found my mother, or sister, better today." They also leave the babies to be taken care of by the service bureau. It is a very satisfactory thing.

THE CHAIRMAN: "Are babies booked as patients?" We have always taken the stand that it takes as much time of the nurse to take care of a new born baby as it does the mother and is just about as expensive as a patient. Therefore we class them as patients. We even go farther than this and assign them to a pediatrician, so that if any baby needs medical attention the doctor is there to care for it.

A MEMBER: Do you do that with private patients, too?

THE CHAIRMAN: Every baby that is born in the hospital, although I am speaking particularly of the ward pa-

tients. Are any of the superintendents here counting babies as patients? The reason why this question is important is, that in making out annual reports, some of us count them as patients and some do not, and we should have some standardization in our reports, which are otherwise more or less confusing. With us we have around nine hundred babies a year and that adds that many more to our list of patients. Another hospital will not include them. Therefore, if you want to compare the statistics of the two hospitals, it would be confusing and would not be fair to either one.

A LADY: I admit our babies as patients and give them a number and charge a dollar and a half a day.

A MEMBER: We give every baby a serial number and count it as a patient. They have to be accounted for. We also count X-ray patients.

THE CHAIRMAN: I do not understand how you can count an X-ray patient who does not remain in the hospital as a patient and give him a serial number.

A MEMBER: We count everything. Every patient that comes into the hospital has a serial number whether he remains or not.

THE CHAIRMAN: They should be classed as out-patients, not as patients in the hospital.

MR. RICHARDS: I make a motion that this meeting go on record as counting "all new born babies as patients."

The motion was seconded and carried unanimously.

DR. I. C. GARY, of Chicag: Having settled the question that babies are hospital patients let us settle the question as to what constitutes a hospital patient. A previous speaker has said he included all X-ray patients as hospital patients. In my hospital I count only patients who are put to bed as hospital patients.

THE CHAIRMAN: That is a very important matter, Dr. Gary. You are correct; only such as are put to bed should be counted as hospital patients. I have never counted any one as a patient who has not been admitted and assigned to a room and have remained long enough to have received some medical attention. If they are admitted, go up to their room and change their mind, we simply mark across the admittance ticket and on the front sheet of the history, "Did not stay," and they are not counted. I think that is very important because when we make up our annual report and give a list of our patients during the year, we should only list those that have been ad-



mitted and assigned to a doctor and had some medical attention.

DR. WAHLSTROM: What is the general practice with regard to X-ray patients? Are they not to be registered when they come in for treatment?

THE CHAIRMAN: We do not give them a serial number; they are counted as out-patients, and the record sheet is so marked.

MISS BESSIE NORTON, Winchester, Mass.: I should like to know the opinion in regard to a patient who comes in to be treated for tonsilitis and adenoids and goes home the same day? Should he have a serial number?

THE CHAIRMAN: I would like to answer that question. Our hospital passed a rule several years ago that no patient could be admitted for tonsilitis and go home the same day; such patients must remain at least over night.

A MEMBER: I would like to know whether the members regard the mothers as patients.

THE CHAIRMAN: We count them as attendants. These attendants are mothers or relatives of patients who remain in the room with them, but they are not counted as patients. We charge \$5.00 per day for a cot and meals.

MISS ROGERS: Sometimes the mother cannot always stay with the patient. Now, there is a difference of opinion as to what is right or wrong. I think it is very important for the Association to decide whether the patient can come in in the morning and be operated on in the morning and go out. We have made a rule that the patient must come in the night before. I would like to know just what the opinion of the meeting is regarding that very important point.

THE CHAIRMAN: In answer to Miss Roger's question, I will say that we do not insist on tonsilitis patients coming in the night before, but we do insist upon their coming in early enough so that a careful examination and cultures can be made. We have a rule that they shall come in not later than ten o'clock in the morning, where they are operated on at two o'clock in the afternoon. We will take up the next question: "How many hospitals permit internes to be the first assistant at major operations?"

MR. HILDRETH: We insist upon it.

A MEMBER: The interne in all cases is not called the first assistant until he has been at work a sufficient time. It takes about a month for an interne to be able to prove that he is capable of being a first assistant.

THE CHAIRMAN: Anyone else have any suggestions? I would like to have all members who permit their internes to be the first assistant at major operations raise their hands.

(A great majority answered in the affirmative.)

THE CHAIRMAN: It might be interesting to those that do not to know the reason why. I would like to ask one or two if there is some reason that might be of interest to the members of the convention?

A MEMBER: We generally have our associate surgeons assist in a case and the interne as a second assistant.

A MEMBER: In Pennsylvania, the State Board of Medical Examiners requires that the interne shall be the first assistant in most cases. The same is true in New Jersey.

Session adjourned.

## SECTION ON ADMINISTRATION

September 14, 1921, 2:00 P. M.

Dr. A. C. Bachmeyer in the Chair.

CHAIRMAN BACHMEYER: Heretofore in the Section on Administration, the program has consisted in the presentation of interesting and instructive papers. In preparing this year's program it was believed that it would be of greater value to the Association, if some phase of Administrative work were considered and if as a result of that consideration, some definite action were taken, whereby the Association would approve of certain methods of procedure or principles of Administration. We are, therefore, devoting the entire program to a discussion of records, or of the methods of recording institutional activity. Originally it had been planned to limit the program to a discussion on vital statistics, but following the appointment of the special committee on forms and records, it was believed that that report had best be presented in the meeting of this section and the program was changed. The papers to be presented will however, enable us to pass resolutions, placing the Association on record as approving certain principles of hospital practice.

It gives me great pleasure therefore to present to you Dr. Haven Emerson, who as the first speaker, will talk to us about "How Hospital Records can contribute to Public Health Protection."

DR. HAVEN EMERSON: As the individual physician is licensed so will the collective medical services of the hospital be licensed and in an increasing measure operate under certain standards of location, equipment, and administration and be required to give an accounting of its contact with the sick of the community.

Quoting from the report of the Bureau of Hospitals of the State Department of Health of Ohio, January 1, 1921, the following are significant opinions widely held but not yet universally recognized or effectively acted upon throughout the country:

"To appreciate thoroughly the public character of the hospital it must be regarded as a public utility.

The hospital is essentially a private corporation filling a positive public need. Its sole function is the protection of the public health, and the difference between

efficient and inefficient hospital performance is the difference between life and death of human beings.

Again the functions of these institutions recognized as public utilities are executed by lay individuals while hospital functions are largely administered by a professional personnel, principally physicians and nurses who are licensed or registered as individuals by a public office upon their demonstration to meet prescribed qualifications.

Moreover, hospital functions embrace activities beyond the scope of medical and nursing practice, and independent of all medical service and the most accomplished nursing can give.

It is those facilities and activities constituting the difference between home and hospital care that differentiate between medical practice and hospital performance."

It will be recalled also that various summaries of hospital services have shown that from 85 to 95 per cent of all hospital beds are in institutions supported by taxation or by voluntary subscription of the public, and are operated, without financial profit, for the benefit of the public.

It may as well be admitted that the sick with certain group exceptions receive more prompt and accurate diagnosis of their conditions and are treated with better success in hospitals than in homes. Furthermore, expressing the opinion of the Council of Health of the American Medical Association we may agree that the future of curative and preventive medical practice depends upon the provision of such hospital, laboratory, and dispensary facilities supported by the public as will permit the application of modern science in a way impracticable through the agency of individual or competitive medical practice.

Granting then for the sake of argument that hospitals are at present and will be in the future to an even greater extent public utilities serving public needs without thought or object of gain other than in merit and credit in public esteem, are they serving all the functions now possible and expected of them in the preventive aspect of medical practice?

To stop a moment before answering directly, let us recall what is the information contained in hospital records. One section would be financial and what may be called administrative, another social, and the third medical.

Doubtless there are to be found values in health protection in the first two but if so the study of this must come from other sources.

With the medical information I am prepared to deal.

Of what does the clinical record of a hospital and dispensary patient consist? There must be social, scientific and administrative facts. There are the patient, the physician, and the hospital to be protected against inadequate service, against loss of data precious to the patient and to society, and against claims that there has been malpractice or neglect. Facts upon which improvements in hospital procedure and management can be based, by which policies and the principles of administration can be tested, require an analysis of the experiences with disease, which the bedside and laboratory service offer. Health, human salvage, relief from pain, from disability, from fever and from anxiety, and postponement of death—these are the hospital's output. How success is attained or failure results, because of or in spite of our knowledge or our ignorance; what is myth and mystery, what is superstition and sentiment, to answer such queries, we turn to the record. The record, not our imagination or our memory of past events, but a painstaking entry on imperishable human documents of what is at the same time the glory and cause of humility of medicine, the truth *as we see it, when we see it*, the fact as our faltering and unskilled senses take note of it, on the spot, in the presence of suffering humanity, at the autopsy table, while the reaction in test tube or the tissue fragment under the microscope are knocking at our consciousness.

The hospital is the great court before which our social order, our education, our personal habits are exposed in all the tragedy of our failures. How dare we continue our stewardship, we the responsible directors of the human salvage plants, we the servants of the sick offering them what we have acquired in the way of science, art, and spirit if we do not as modern apostles write down the record of the lives we are temporarily entrusted with.

There is no physician so experienced, or so endowed with intuition that he can make a diagnosis of a *patient*, without a clinical history. A diagnosis of a *disease*, a fracture, malaria, syphilis, diabetes, may be made in the absence of history. But what of the *person* who is sick? Can we afford to know less than all that can be discovered of inheritance, of home, family, background, incidental and ancient difficulties of body and spirit, what has been

suffered, what met and overcome? Even the speechless babe has a history, even the patient of foreign tongue needs to tell us what we ought to want to know. A history taken is stolen if not recorded.

The day of clinical impressions is past. We no longer walk in awe at the elbow of the great clinician who makes a diagnosis at arm's length. Diagnosis demands a complete and detailed physical examination of the patient and often a mental study too. Not a study of the lungs only when we expect pneumonia, or of the joints when we talk of rheumatism, but a study of all the body to find out all that is wrong and all that is right and thus save us the humiliation of seeing patients return time and again to the hospital for what should have been corrected at the first admission.

We expect a diagnosis to be more than a guess. It is an opinion of importance and is to be recorded in the interest of honesty. To be proved wrong in a tilt with the incomparable complexities of disease is no disgrace, but to be faced with a record of error is chastening to the spirit and in the right kind of physician whets the intellect.

Is treatment a votive offering to strange gods or is it a rational application of relief following an opinion as to cause, course, and expected outcome of disease? If it is worth giving or doing, it is worth recording so that it won't be done again if it fails, and to give proof of intelligent endeavor if it is successful.

Disease is no more a fixed condition than is health. Health is human reaction and, until death, is never stationary. Progress to health or into more desperate disease is human history and if only for historical purposes would be worth recording. That a patient enters a hospital with pneumonia and is recorded as dying under operation for empyema leaves too much to the imagination, and among the imaginings will certainly be the suspicion that the listening ear and the testing hand of the examiner lacked industry in the daily search for explanation of persistent fever, and delayed resolution. In any event the progress from pneumonia to empyema is important to science and if recorded may save the next patient's life.

Then when our worst or best is done, when the patient leaves the hospital a living cripple, a healthy convalescent, or when postmortem examination closes the story, shall we be so glad or so sad that we simply note the final date



with no estimate of result, no summing up of experience? Shall we dismiss our friend the patient, knowing well that he knows nothing of the cause or means of preventing a repetition of his digestive, his nervous, his occupational disease? Shall we lose the asset of gratitude, the willingness to learn from those who have helped in sickness, and turn the mother loose with no inkling of the laws of health, the necessary precautions which should see her through the early months of the baby's life and her own first maternity convalescence?

In such spirit is the true clinical record taken. With all charity and reasonableness let me report what I have found in a study of 1,000 records of patients recently discharged from twenty of the hospitals of a large municipality.

Six hundred and fourteen had something in the way of a personal history of the patient, and of these not more than 200 could be considered a really adequate clinical history. In other instances a recital of the complaints of the patient or simply a statement of the duration of the present illness were considered adequate for the personal history.

In 528 cases there was some entry of the physical examination of the patient, but of these records not more than 350 showed what would be considered as an adequate examination record upon which the diagnosis might properly be based.

A working diagnosis was given in 684 instances.

Laboratory findings, chiefly routine examination of urine, was recorded in 514 instances.

The treatment as indicated by operative procedure or medication was recorded in 717 cases.

Final or corrected diagnosis, that is, condition on discharge or after operation or confirmed or corrected by pathological findings, was recorded in 560 cases.

Four hundred and thirty-four showed a brief statement of the condition of the patient on discharge, that is, whether improved or unimproved or whether death resulted under care.

Progress notes were found in 381 records and this term has been very generously interpreted; in not more than 150 instances did the record include entry of the observations of the visiting physician or surgeon or of the staff as they examined the patient from day to day during the course of the disease.

In only six of the hospitals whose records were studied could the records of patients be considered adequate either for clinical study by physicians in charge of the patient, by the hospital authorities to determine the character of the work they were responsible for, or by students of clinical medicine who might wish now or later to test the experience of others against new scientific facts and theories.

At only four of the hospitals was there any systematic attempt to make a periodic analysis of clinical experience while the contact with the case was fresh in the minds of the physicians, and in only two of the hospitals of the city, was this clinical conference carried out with sufficient detail and completeness to meet the objects of such a professional undertaking.

It must be understood that records should be filed by disease whatever other files and filing indices may be used. And the index card under disease should show the authorship of the record or in other words the physician or surgeon under whom the patient was cared for. A few hospitals in that city have adopted this principle of filing.

The completion of the record before filing is very loosely provided for in most hospitals. The medical responsibility in the case is followed up in most instances if at all by a clerical representative of the superintendent's office. Elsewhere the follow-up is left to a nurse in charge of the record office. Good practice and sound principle would seem to require that the medical staff themselves should provide such oversight of clinical histories and records as would insure the records being complete in every detail before leaving the ward for the record room, and as promptly as possible after the discharge or death of the patient. The assignment of an assistant on each service to guarantee the professional completeness of history records is valuable insurance against neglect and carelessness.

Where records are typewritten, as is the case in several hospitals, the appearance of the sheets is vastly improved, and where physical examinations and histories are dictated, there is no economy in having the transcribing done by hand.

Physical examination, histories, progress notes, pre-operative, postoperative, final diagnosis, autopsy, condition on discharge, should all be initialed so that the responsibility for the facts recorded or the opinions expressed can

be directly traced. It is not thought that there is any real advantage to be gained in the teaching of medicine by the withholding from the student observer, the well considered opinion and diagnosis of physician or surgeon in charge.

Of great convenience for the future use of the histories is what is known and prepared in several hospitals as a summary sheet to be attached to the front of the chart showing the completion of the record with regard to family and personal history, physical examination, diagnosis, progress notes, final diagnosis, postmortem findings, condition on discharge, etc.

In the main, the hospitals apply the same system good or bad for pay, part-pay, and free patients alike, but there are instances where the records of the free patients are far superior to what is entered for the private patients. The presumption that the physician for a private patient has taken a history, made physical examination, and has ascertained the facts usually included in routine laboratory tests may be satisfactory to the hospital, but as a general principle it can be said that irresponsibility and carelessness of method go hand in hand with failure to record observations or to commit one's self to positive findings and opinions. In answer to inquiries which those outside of the hospital circle are bound to ask, namely, are the records sufficient to make possible comparison of hospital method, professional services, and scientific results, we must acknowledge the fact that not more than 25 per cent of the records of patients in these hospitals are taken or kept in such a way as to be of any value whatsoever to the science of medicine or for study of the principles of hospital administration. It is taken for granted that when hospital records are completed and filed they should be accessible to properly accredited workers now and in the future, no matter what their department or the cause for their interest—be it social, medical or administrative.

Briefly I find myself in complete accord in this regard with the minimum standards which have been proposed by the American College of Surgeons—"That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital, a complete case record being one, except in an emergency, which includes: the personal history; the physical examination, with clinical, pathological, and x-ray findings when indicated; the working diagnosis; the treatment, medical and surgical;

the medical progress; the condition on discharge with final diagnosis; and, in case of death, the autopsy findings when available." We should add however a further item, namely, that before a patient leaves the hospital, he should be instructed by the physician or under the physician's direction by the social worker or other competent adviser, as to the cause of his illness, what he may expect in the future in the way of recurrence, how he may avoid repetition of his malady or infirmity, and such necessary elements of the laws of hygiene and personal conduct as will make the patient his own best protector of his health in the future.

Furthermore I wish to endorse heartily the recommendations of the American College of Surgeons in regard to the periodic analysis of clinical records as follows: "That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analysis."

Nothing more valuable for the betterment of hospital administration and service can be conceived than an honest measurement of failures and successes as demonstrated by the relentless inquiry of a group of fellow workers within the hospital family.

As a warning to those who would exalt records above results, allow me to suggest that the hospital should avoid the danger of developing records for their own sake. There must be due regard maintained as to the value of the records in relation to the other activities of the hospital. The hospital needs not merely to learn results but also to produce results and then keep itself informed as to what these results are. The hospital that merely finds out what results are, may be said to have a "fish-up" system instead of a follow-up system. Learning what the patient's needs are while the patient is in the hospital or what the possibilities of after-care are in the patient's home environment, then making the patient understand these needs and possibilities, are essential factors in producing results, often just as essential as the after-care itself. In other words there should be an intimate connection between the activities of the social service department and the system of finding out the medical results at certain periods after the patient has been discharged. Unless there is such a connection, the follow-up system becomes mechanical and separated from the positive crea-

tive activities of the hospital. The social service department should be expected to furnish to the physician facts regarding the home conditions and other items regarding cases which will assist the physician in making the program for after-care. In the second place, the social service department will aid the patient to understand what this program for after-care is, and thirdly it will help the patient to carry out the program effectively. Accurate and complete medical records are indispensable as a basis of the after-care of the patient.

I know of no better investment for the sake of acquiring public credit, hospital self-respect or for meeting the standards of service than requiring and providing for the taking and keeping of clinical records of patients.

Science advances on the back of accumulated facts.

Up to the present time with rare and individual exceptions the information given out from hospitals has been dry and valueless, and may be called the dead ashes of the great repair shops of humanity.

Hospitals report births, deaths, and in general according to their lights and the local enforcement of the law they report notifiable diseases, (preventable, communicable, and occupational, reasonably completely). Public health administration has moved too rapidly to be served by such reports, and needs now not only the fact of death but the fact of sickness in all cases. No longer do we wait for the death rate to betray an epidemic. We go into the homes and search for the sick on the first suspicion of presence of various diseases and put them, if possible under hospital conditions of isolation. We do not look to the registrar's record of deaths from lead poisoning or enteritis of infants but we send inspectors and nurses to search for patients while they can still be saved.

In other words just as the curability and preventability of tuberculosis, syphilis, appendicitis, diphtheria, and heart disease depend on early and accurate diagnosis, so the presence of a malady in the community must be early recorded if we would prevent or cure community ills.

Briefly, what would be the greatest single addition to the material upon which modern health protection is based? Abundant, prompt, accurate data on the existence and sources of all diseases.

To require this of the individual practicing physician will be impracticable for a long time to come since neither he nor his patients yet appreciate the necessity of report-

ing even the serious communicable diseases with any great degree of completeness.

Current morbidity data could be supplied by the hospitals as suggested in the chapter on a system of vital statistics for a municipality by Dr. Dublin. (Part II, Cleveland Hospital and Health Survey, pp. 369-371) :

"In no American city of any size is it possible to give the total number of cases admitted to hospitals, both public and private, the diseases for which entrance was sought, the age and sex distribution of the patients, the duration of treatment and the result of the treatment. It is a blemish on the excellent work done by hospitals that this phase of their activities has been left undeveloped almost without exception in the United States. . . .

The necessity for such records of hospital care is never questioned; but nowhere have the necessary steps been taken to assure the receipt of the facts. In the matter of organization, it would be necessary only to establish a central office, preferably in the bureau of vital statistics of the city, where uniform reports would be received from each of the hospitals of the city for each case on its discharge. Such a standard form would include such basic items as age of the patient, sex, color, nativity, occupation, duration of residence in Cleveland, address, diagnosis on admission and at discharge, a brief summary of the treatment, duration of the treatment, the date of discharge and condition on discharge; a statement of the social service work done or contemplated would make a valuable addition. It would be necessary only for the hospitals of the city to agree upon a simple blank including such items as these, and to send them as completed to the central record office immediately upon the discharge of the patient. A nomenclature and classification of diseases and of conditions or states of the patients on discharge should also be agreed upon. . . .

In the central office these records would be edited and otherwise prepared for transfer to perforated cards which would then be sorted and tabulated by mechanical devices. At comparatively low cost, it should be possible at the end of each quarter and at the end of the year to have available a series of tables showing for each hospital and for all hospitals combined, the essential facts for the cases discharged during the period."

The initial suggestion in this field is to be found in the Reprint No. 5 of the Department of Health of New York City by Dr. Charles F. Bolduan, April, 1913, which gives details of a method which would produce invaluable information to permit of a check and estimate of the relative value of treatments, and a basis upon which an intelligent municipal program could be developed.

Dr. Bolduan however proposed data obtained from a discharge card, while many of the benefits to be expected from hospital reports can come only from a daily record



of diagnosis of each case as admitted, with changes of diagnosis as later established.

The discharge card record is perhaps the first step in introducing such a system and the value of this is emphasized also by former Assistant Surgeon General John W. Trask in Public Health Report Supplement No. 12 of April 3, 1914, and by the work of Frederick L. Hoffman in his study of 1913 in the Johns Hopkins Reports.

Other statisticians, including Raymond Pearl, have not only availed themselves of hospital records but have indicated the value in public health work to be expected from further analysis of such data.

As we have been pushing back the date at which helpful preventive efforts to save maternal and infant life may profitably be employed for the expectant mother, so in an intelligent attack upon sickness we must push our inquiry back towards the date of health and far prior to the death date which is now our index and criterion of results.

Not only hospitals, but dispensaries are in a strategic position which must be used in advancing our knowledge both as to the quantity and quality of sickness, and as stations where the results of preventive measures may be detected.

We talk glibly of health protection, of health leagues, of health departments, and when we analyze their work we find them engaged chiefly in the treatment or alleviation of the end results of disease.

To drop the death rate we split up the reports of deaths into individual causes, and attack our fagot in the old way of the fable by breaking them one at a time, now a big one like infant mortality, now a tiny one like rabies, until the rate has been brought within reasonable distance of a practicable statistical ideal.

Death is often a release not only for the individual but for the community and the dependents. It is sickness, pain, fear, anxiety, that saps human happiness and drops the level of so-called health, which is often merely a label for "being up and about."

Before we can claim to be developing or even protecting health we must know the sum and character of human sickness. Our first and best and perhaps our last source of information will be the organized medical service shops, the hospitals, and dispensaries, the sanatoriums, convalescent homes and domiciles of the insane, of children, of paupers, and those great institutions now infiltrated throughout the community, the visiting nurse associations,

whose experience and records often present a greater range and bulk of material than the larger hospitals of a city or state all combined.

It has been the story of this country that most of the permanent constructive progressive movements in public health have come from private initiative, and later have been assimilated into official policies and administration, and later still have been so approved of as to become incorporated in the sanitary law of the community. It is my suggestion to this association that you authorize a committee on hospital morbidity reports, whose duties shall be at least to enlist the cooperation of some organized hospital group, such for instance as that represented by the Cleveland Hospital Council to the end that uniform daily reports of admissions, discharges, transfers, deaths, and changes in diagnosis of all hospitalized patients be reported at a central point and there be tabulated and issued at least once a week for the information of the public officers of health and of the practitioners of medicine, and if possible be printed currently in the public press.

It is my belief that in this way necessary knowledge will be promptly available for professional use, and the public will be gradually educated in the true extent, the seasonal occurrence and the occasional formidable proportions of various common diseases.

There would be technical and educational value in the mere mass and currency of the figures, and I am confident that such a system once installed would be found to improve support for all variety of diagnostic, preventive, and curative medical work.

How we have blundered along without it, is hard to see, and once initiated, current hospital morbidity reports will be found as much taken for granted in the scheme of community self-protection as is the weekly report of births and deaths, and of vastly greater ultimate value.

While we now look askance at the states which have failed to meet the minimum civilized requirements of registration laws for human births and deaths it is not unreasonable to expect in the next generation a similar development of public opinion in favor of reports of sickness as it occurs.

Health officers recognize the need, the material is present in abundance, there is lacking only the energy and capacity of a leader among hospital people to take this next step forward. There is no doubt in my mind

but that the American Hospital Association will reply as it has always done in the past to each new opportunity for public service. The opportunity awaits you.

CHAIRMAN BACHMEYER: Dr. Emerson's paper is now before you for discussion.

DR. HOWLAND, of Boston: I do not see how any one of us can do less than subscribe to every word Dr. Emerson has said. I would like to make one suggestion which would be helpful perhaps in completing the record and that is the method of following up the patients for a period of a year or two, which of course in every case is not sufficient to complete the history, but a year or two is pretty good. If you have attempted to follow up the patients you have found that a very considerable percentage of them have disappeared, that you cannot trace them. It is an administrative duty in my opinion, to provide every possible aid to the clinician, to the record room or whatever department carries the follow-up, and I would suggest that every admission card should have carefully recorded on it the admission history, and the name of the recommending physician. Many do that. In six months or a year, we wish to follow up that patient, and we write to the address on his admission card. The patient has disappeared. What do we turn to next? We find out who recommended him; Dr. Smith. We did not get his initials or his exact street address; therefore we have failed to get assistance from this source.

We have found another thing that is helpful; Dr. Smith may have seen the patient only once and may know nothing more about the patient after his discharge from the hospital than we do. It is to ask each patient to give the permanent address of a friend, relative or acquaintance in business. They may give the name of somebody who is in business in a store or a lawyer or some other professional man and if he is a friend of that patient he is very helpful in following him up. I think those two lines for the address, the permanent address of a relative or friend and the careful record of who the recommending or family doctor is, are essential in any follow-up system.

DR. SUTTON, of Zanesville, Ohio: Dr. Emerson does not seem to realize that we have run out of general practitioners. We really do not have any in our part of the country, scarcely at all, any more, and conditions are bad and there has been nothing suggested to solve the problem. The Hospital Associations assume the responsibility of furnishing nurses, educating nurses. Now we are

not satisfying the demands of the people in the rural communities at all. In the first place, the requirements for admission to training schools are too high already. Medical legislators are advocating still higher requirements for admission to training schools, and the same applies to the medical colleges. I have travelled throughout five or six states within the past couple of months, and visited a great many small towns, and I find that the same condition exists everywhere, and I have no possible doubt but that it exists all over the United States, and nothing is being done, no suggestion of any solution of this most serious problem. To give you an example, I practice in a town of thirty thousand, and I have made a point of interviewing quite a number of the doctors of the surrounding country that I gather patients from. For instance, one large county, large in area, with a population of something like twenty-four thousand people, fifteen years ago had 35 physicians. Today they have 10 and half of those are in the county seat. All of them are over sixty years of age except one, and he is only about my age. Now those people are in distress, and so far not anything has been said at this meeting of these great men, and this great organization that is supposed to look after the sick and suffering, not anything has been suggested to solve that problem. We cannot get nurses. I have charge of the biggest hospital in southeastern Ohio, and I cannot supply nurses to the best friends I have in the world; they are obliged to do without them. I interviewed some of the physicians that bring cases to me. They all tell the same story. Only the other day a man said "I will be in tomorrow with four cases to be operated on right away because I must get back." I said "All right, doctor, I will have my big machine there and you can send more if you want to." Those of us in the harness are living on the fat of the land and have been for some time, but we are running clear out of general practitioners and it is the same in Iowa and Michigan as it is in Ohio. Do you know that the average physician in Michigan and Iowa is reported to be over 65 years of age? What is going to happen and what is this great organization doing to correct it? There is nothing on the program to suggest that this most lamentable and distressing condition that faces us today is going to be met. If we are caught without a program in the near future with which to meet this situation in the next five years, we are going to have some legislation from the people that is going to be most pernicious

for hospitals and the medical profession. I tell you that the future of the medical profession is in peril, and every man, as William J. Mayo said at St. Paul at the meeting of the National Catholic Hospital Association, every thinking individual knows that this scarcity of nurses and physicians throughout rural districts exists. How are we going to carry out the splendid recommendations of this man Dr. Emerson, without student nurses and medical students?

CHAIRMAN BACHMEYER: Dr. Sutton's remarks are not germane to our discussion, but I know that he has delivered a message that needs consideration, and I recommend to him that he take it to our Board of Trustees for their consideration. Mr. Chapman, we have just a few more minutes for this paper, if you will be very brief.

MR. CHAPMAN: Dr. Emerson said something about putting the responsibility for checking up end results of histories on our medical staffs. With all due respect to him, I do not believe he meant it. I believe our medical staffs, must of necessity, be made to feel the responsibility for this checkup, but I do not believe you can ever get results with medical histories unless it is definitely the obligation of the administration to see that the medical staff does it. I think that the reason most of our hospitals have poor histories, is because they have passed the responsibility to the medical staff. So far as having a member of the resident staff responsible for those histories, bear in mind the status of that resident staff as regards the attending man. The resident staff says "Doctor, sign this history;" and he says "I will do it tomorrow." Whereas, if a member of the administration says to that doctor "Within 24 hours we want these histories signed," or if he does not sign them says "Doctor, we want this signed now," if you have any control over your attending men you will get proper histories, but you will never get them unless you assign that as a definite administrative obligation.

CHAIRMAN BACHMEYER: Dr. Emerson has brought to us a recommendation that we may want to take note of. He says "It is my suggestion to this body that you authorize a committee on hospital morbidity reports." I gather from this that it is his suggestion that we have a committee that would endeavor to begin a movement whereby hospitals would render morbidity reports. What is your pleasure with this recommendation?

MR. CHAPMAN: I move you, that it be placed in the hands of the committee on records and forms for such action as they may deem necessary.

(Mr. Chapman's motion was seconded and adopted.)

DR. EMERSON: Might I say just a word in reply to Mr. Chapman? As an assistant physician at Bellevue, I was fortunate enough to be assigned as junior attending to the checking up of all the histories on the medical wards of that particular division. There was a clinician in charge who was the head of the service, who spent most of his time on hospital work, and the records were made complete because the visiting physician on duty held us juniors responsible for their completeness. Now of course exactly that same course can be taken by the administration which appoints the juniors, but I think that there is a certain merit psychologically in holding the professional men responsible for the completion of their professional jobs. I do not consider that anybody is as interested in records as the doctors who are making them. If a doctor is not interested in recording what he has done and making it so clear and definite that anybody can detect either his success or his failure afterwards, I do not believe that any amount of administrative pressure will make those histories complete. That is why I think that theoretically it would be wiser to hold the medical staff responsible for that just exactly as much as for putting the dressing on a patient after he is operated on. If that method fails, of course the hospital must, to maintain its own discipline and its own self-respect, require completion of the records by the physicians.

CHAIRMAN BACHMEYER: Dr. Faxon will present his paper on Vital Statistics a Hospital Should Collect and Publish.

DR. NATHANIEL W. FAXON, Assistant Resident Physician, Massachusetts General Hospital, Boston: Vital Statistics is that portion of demography that applies the statistical method to the study of vital facts, such as birth, marriage, sickness and death. The statistical data of hospitals form that portion of general sickness and mortality statistics that we are interested in considering, and includes not only the vital facts relating to sickness and death but also other facts concerning patients in hospitals.

Hospital statistics fall naturally into three groups:

1. Statistics dealing with the admission and discharge of patients, age, sex, race, occupation, and similar



facts; patient's days treatment, average days of treatment per patient, number of empty beds, and other data indispensable to the administration of the hospital.

2. Statistics dealing with the medical or surgical history of the patient, including diagnosis, operation, pathological findings and autopsy, and the facts concerning morbidity and mortality.
3. Financial statistics, which include a detailed account of the receipts and expenses of the various departments, the cost per patient per day, cost of food per capita, and other costs by which the efficiency of management may be determined.

Vital statistics relate only to the first two groups.

The preparation and study of hospital statistics has in the past shown the efficiency of methods of treatment, such as serum therapy and of operation in surgical conditions. It has also shown the seasonal prevalence of certain diseases and the increase or decrease of a given disease during a period of years.

Hospital statistics serve to act as controls to crude vital statistics through their exact laboratory methods and autopsies. There is also great opportunity to add to vital statistics, through the study of the incidence of non-fatal disease. Both of these groups are of aid to public health administration.

Statistical study of hospital data is indispensable in establishing administrative programs for an institution.

The fields of service of hospital statistics are therefore:

1. The advancement of medical and surgical science.
2. The aiding of public health administration.
3. The assistance of hospital management.

To serve a useful purpose in these several fields hospital statistics and hospital reports must fulfill three distinct purposes or conditions:

1. They must be statistical or scientific and complete.
2. They must be arranged for development or interpretation.
3. There must be some measure of efficiency of service.

It is obvious that all hospitals cannot collect and arrange all their statistics in a similar manner. A hospital treating only tuberculous patients can find few lines of comparison with a general hospital, and a state infirmary treating only free patients may find its tables widely at variance with a hospital treating mainly pay

patients. Even in extreme cases, however, certain common grounds for comparison may be found as in the statistics concerning individuals with a common disease and similarity of tables may be had by the use of a common nomenclature of disease. But for a general comparison hospitals must be grouped according to their size and the class of patients that they treat, into:

1. General hospitals treating both pay and free patients and affiliated with some medical school and designated usually as teaching hospitals.
2. Non-teaching hospitals.
3. Special hospitals as mental and psychopathic, tuberculous, and eye and ear.

A distinction must also be made between house or non-ambulatory cases and out-patient or ambulatory cases. In this paper consideration is made only of house cases in general teaching hospitals of about 500 beds, although the general principles laid down will be applicable to other hospitals and to out-patient departments.

A general hospital then, should collect complete statistical data on each case, arrange these data so as to be readily accessible for use, and study them to determine the efficiency of treatment and management.

"Invaluable logical conclusions may be drawn from complete statistical tables but the conclusions drawn from incomplete tables are always fallacious."<sup>1</sup> The truth of this assertion is shown by the comparative death rates at the Johns Hopkins Hospital 1902-1911.<sup>2</sup> Two factors only are considered, mortality and color.

Total death rate.....	5.8
Death rate, white males.....	5.1
Death rate, colored males.....	12.6

From this table it can easily be seen that if only the total death rate was considered, an entirely erroneous conclusion might be drawn in regard to the death rate for colored males, which was over twice as much. This clearly shows the need of complete tables covering all factors.

One of the common defects of histories is that they leave many important questions unanswered. One of the remedies is a series of blank forms with spaces for the recording of answers to definite questions. Another method is the use of an outline for the history taker to

1. A. S. Percival, M.A., *How to Read Statistics*, British Med. Journal 1919, p. 540.

2. F. L. Hoffman, LL.D., *The Statistical Experience Data of the Johns Hopkins Hospital*, Baltimore 1892-1911.

follow so that he may not overlook important points without being obliged to conform to a stipulated form. In both cases portions of the history are to be written with entire freedom from such rigid devices. The blank form is from the statistician's viewpoint more desirable, while the other appeals more to the clinician. In either case the data collected should bear the signature of the person responsible for them.

However obtained, a complete case history should contain the following information. Some of it concerns vital statistics, some is of use only to the hospital administration. All is necessary.

1. Serial number.
2. Date of admission.
3. Service and ward to which admitted.
4. Name.
5. Residence, to determine the geographical area served by the hospital.
6. Sex.
7. Age.
8. Color.
9. Nationality, as determined by mother tongue.
10. Social status: single, married, widowed, divorced, separated.
11. Industry, as shoe factory, and occupation, as laster. Employers' name in some cases.
12. Whether or not a re-entry.
13. Body weight and stature.
14. Duration of stay in hospital.
15. Condition on admission: Acute, chronic, accident, for diagnosis, normal (pregnancy).
16. How discharged: Untreated, against advice, dead, otherwise discharged.
17. Medical history, including family and past history, present illness and physical examination, admission diagnosis, preliminary or pre-operative diagnosis with complications, final or post-operative diagnosis with complications, surgical operation with description by the operator, anesthesia, report, treatment and bedside notes at least twice a week, laboratory findings, pathological reports, autopsy report if performed, and special data on special diseases. Social case histories are becoming increasingly useful and will doubtless in time become a part of each individual's history. At least social service number should be entered.

18. Birthplace.
19. Birthplace of father and mother.
20. For purposes of notification, names and addresses of two relatives or friends.
21. Name and address of patient's physician.
22. Whether pay, part pay, or free, and rate charged.
23. Number in family and weekly wage.

For good and sufficient reasons, hospitals may add or subtract from this list, but for routine purposes this list may serve as a basis.

Experience has determined certain methods of assembling these data in record rooms.

1. Name catalogue, giving the data collected on the admission slip, together with the discharge data, and the proper reference for finding the record in the files.
2. Diagnosis catalogue of individual cases.
3. A compilation of statistics, kept on cards and arranged by years and subdivided to show sex, whether medical or surgical and division of each, and mortality.
4. Operation catalogue, filed under diagnosis and showing the operations performed.

Experience has also shown that such catalogues but imperfectly supply information. They readily answer what may be characterized as the obvious, but are able to assist but slightly in the study of the unknown. The solution is the use of perforated cards and mechanical tabulation. Professor Raymond Pearl of Johns Hopkins Hospital says "the first duty of a hospital statistical department should be the transferring of the basic routine facts from all case histories to punched cards for the purpose of indexing, assembling and tabulating."

The most generally useful and flexible systems of mechanical tabulation are those known as the Hollerith system, from its inventor, Herman Hollerith, and a modification of this made by the Powers Accounting Company. By their use a large number of data are easily transferred to small punched cards and almost any conceivable grouping of data obtained through mechanical sorting and recording machines.

For instance, if it is desired to determine the number of cases of appendicitis in Italian children under ten years of age, we have only to set the sorting machine,

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1. "Modern Methods in Handling Hospital Statistics," Raymond Pearl, Statistician to the Johns Hopkins Hospital.

first for appendicitis and by running all the cards for the year through to get all the cases of appendicitis. A second setting for race and run will produce all the cases of Italians. A third setting for age and run will give the number of Italian children under ten years and from these cards we can obtain and study further the case histories. All sorting is done at the rate of 250 cards per minute, so that the whole procedure occupies but a mere fraction of the time that would be consumed in sorting similar data from a card catalogue, if indeed it could be sorted at all.

No card catalogue can foresee the questions of investigators, no hospital can afford the labor and expense of hand tabulation of these unexpected questions. Mechanical tabulation is the nearest means of providing for this yet devised. It is in successful operation at the Massachusetts General Hospital Industrial Clinic and at the Johns Hopkins Hospital. I do not advocate the abandoning of the card catalogues that have grown up as the result of years of experience; I do advocate the addition of this system to our present methods. Simplification will follow in the natural course of events. That which is unnecessary will be discarded.

One of the immediate results of the use of this system would be the easy calculation of age group morbidity in hospital patients, a grouping advocated by statisticians, but opposed by hospitals because of expense and difficulty.

The data to be recorded on these cards will of course vary according to the ideas of the staff of the hospital compiling it, but in a general way and let us hope for the common good of hospital statistics, it should tabulate most of the data already set down as constituting the statistics that a hospital should collect. The Industrial Clinic at the M. G. H. has developed a card suitable to its peculiar needs and Professor Pearl has suggested one that is in use at the Johns Hopkins Hospital.

One of the important points in order that comparison may be made is the adoption by all hospitals of a common nomenclature of disease. Most hospitals now follow the International Classification; many have developed modifications of this classification which increase its value for use in cataloguing. Two of the most widely known are Bellevue Classification and the Classification adopted by the Boston Hospitals. This latter divides diseases into 41 sections according to well recognized groupings such as specific infectious diseases, diseases caused by animal

parasites, special skin diseases, diseases of the circulatory system, etc., and under each group follows an alphabetical subdivision. Two numbers are given, the number of the section and the international classification number. For cataloguing purposes this gives sufficient accuracy and ease of manipulation. But for use on a tabulation system further subdivision is necessary. For instance, all skin diseases are listed as 10-145, making it impossible to select the cases of psoriasis unless a sub-code with distinctive number is used. The United States census bureau code attempts this, but is rather cumbersome. The imposing of any one hospital diagnosis code upon the other hospitals of the country is undesirable unless such code is voluntarily adopted because of excellence. Probably the ideal code will develop in the course of practice and be adopted through its merit; perhaps some committee may be appointed to study this situation and hasten the compiling of such a code. Until then the International code should be used as a basis in reporting statistics.

"The purpose of filing case histories is two-fold: first, to preserve them, and, second, to do it in such a way as to make them most readily accessible to anyone who may in the future want to consult them. There can be no question that the latter purpose will be best served by the so-called 'unit system' of case histories, in which the hospital's complete record about any one individual forms one separate and distinct volume."<sup>2</sup>

We have now considered the first two methods by which hospital statistics may serve a useful purpose in their several fields, namely, the primary data they should collect and the method of arranging it. There must still be some measure of efficiency.

A hospital may measure its efficiency in two ways: First, by comparison of its own results from year to year; and, second, by comparison with the results of other hospitals similarly situated and caring for similar classes of patients. To compare the results of hospitals having dissimilar factors must lead to misinterpretation.

Dr. E. A. Codman has stated in a very clear and concise manner the logical questions which any individual might ask, to determine the results of medical and surgical treatment.

What was the matter?

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2. Pearl—"Modern Methods in Handling Hospital Statistics."



Did they find it out beforehand? That is, before operation?

Did the patient get entirely well? And stay well?

If not, why not?

Was it the fault of the physician or surgeon, the disease, or the patient?

What can be done to prevent similar failures in the future?

What was the matter and did they find it out beforehand are naturally answered by comparing the preliminary and final diagnoses. These data appear on all the case histories at the Massachusetts General Hospital, but have never been tabulated. A slight step was made in this direction, by the compilation and publication of the studies of surgical facilities, but no general table of such a comparison has ever been made. That such a table would be instructive is self-evident.

Did the patient get entirely well? We have come to realize in Boston, largely through Dr. Codman's teaching, that results must be extended to include the end result of the case, which is really the vital result from the standpoint of the patient. That the patient survived an operation or recovered through some medical treatment sufficiently to leave the hospital is of course worth knowing and recording, but it is of far more vital interest to know the condition of that patient one year, two years or even five or more years afterwards. Consequently additional data must be obtained and added to the case history, through a follow-up system.

At present at the Massachusetts General Hospital on all surgical cases, (expense has prevented the extension to include all cases), a letter is sent one year from the date of discharge, requesting that the patient report at the hospital for examination and advice, or if unable to do so that he write or have his physician write describing his condition since leaving the hospital. This examination or reply is entered on the patient's record. If no reply is received, another letter is sent to the physician who recommended the patient to the hospital. Further efforts are directed through postmasters, and by the aid of directories. The percentage of successful follow-up cases during the last year has been 52 per cent. In some groups of cases, through the interest of staff members, patients have been followed up to ten years and the results noted on their records. The results of this follow-up work have been published only by individual

investigators for certain small groups of cases, but never as a part of hospital statistics, to which they truly belong. Thus only may a hospital truly estimate its medical and surgical efficiency.

Was it the fault of the physician or surgeon? If errors can be shown, staff as well as patients benefit, and incompetency is discovered. Honesty is the best policy for hospitals as well as for individuals.

Was it the fault of the disease? Certain diseases are recognized as at present incurable and in considering end results such diseases should be grouped and due allowance made.

Was it the fault of the patient? If a patient refuses the advice of his physician then he must accept the results, be they good or bad.

It is necessary, therefore, in order to measure the efficiency of a hospital, to add to the accepted routine data the findings of the follow-up system and to compile and study end results. Both card catalogue and tabulation systems are available for this.

The medical staff of a hospital is or should be interested in its vital statistics and the form and accuracy of the medical case histories rests almost entirely in its hands. The collection of a large part of the other vital statistics and the development of all statistics rests largely with the administrative department.

The publication of these data concerns the governing and administrative bodies. Successful collection and intelligent publication can be obtained only by a common interest and cooperation.

Consideration of the comparison of the results of one hospital with the results of others leads immediately to the study of the statistics that hospitals should publish.

The publication of hospital statistics brings us to the consideration of annual reports and other publications wherein hospitals present their statistics. The same field of service exists here and the same tests may be applied as were applied to the collection of statistics. Such publications should increase medical and surgical knowledge, aid public health administration and, through comparison, assist in hospital management. The statistics should be complete, arranged for interpretation, and have some measure of efficiency of service.

Experience and custom has in the case of some of the general hospitals developed a somewhat similar publication of statistics. This similarity is mainly superficial

and comparison is only made after laborious rearrangement and adjustments. Statistics relating to vital facts only are to be considered.

Hospitals usually publish, generally in an annual report, some or all of the following tables:

1. A comparative statement showing the number of patients admitted, treated, and discharged, the condition at discharge or how discharged, average patients per day, (it should also state the average number of empty beds) the division of patients treated into pay, part pay and free, and the total days of treatment. This gives a general indication of the amount of work done by the hospital.
2. A table of residences of patients, which shows the geographical area served by the hospital.
3. A table of the birthplace of patient and patient's mother, intended to show the nationality of the patient, but which in our polyglot population fails lamentably.
4. In some cases a table of occupations, which is of course of slight interest to the student of occupational disease and of none to others and for this reason is often omitted.
5. A table of medical and surgical diseases in terms of the International Classification divided according to disease, sex, and discharge. The degree of completeness of this table varies widely.
6. A table of surgical operations. The method of compilation of this table varies greatly. It is often omitted.
7. Some hospitals have published a table showing the surgical fatalities with a critical discussion of each case, which is in a sense the first step toward the study of end results, but unnecessarily lengthy.

The number and arrangement of these tables varies in all reports. I have seen but three hospitals publishing reports containing similar tables, similarly arranged, and these only for three years. The similarity has now ceased. A large amount of local option would seem desirable, and hospitals should in a general way be allowed and encouraged to publish those statistics that best fulfill the demands of those interested. But for the promotion of medical and surgical knowledge, for the assistance of public health and as an aid to hospital management, the main fields of service for hospital statistics, it is desirable that certain tables be collected on a common basis, with

a common nomenclature and form, and be published by all hospitals. To state dogmatically all the tables that should be published would develop a discussion and probably considerable difference of opinion. Certain tables might, however, seem so universally useful as to admit of acceptance by all.

1. The table showing the number of patients admitted, treated, and discharged with various other data is found in all large hospital reports that I have examined, but there is no uniformity in the arrangement of these facts. In its present form this material cannot be compared. Since such data is universally accepted as desirable, should it not be presented in a similar manner and by a common accepted form?
2. The table of medical and surgical diseases is the next most commonly published table and through the adoption of the International Classification or some modification is in most cases comparable for totals, but here again the similarity stops. Some hospitals further classify into medical and surgical, some by sex, some by admission, others by discharge. Again the need of a common form of report is shown in order that this mass of data may be utilized without prohibitive effort.

The need of cooperation on these lines produced in Boston the organization of a committee of the record librarians of the five largest hospitals to assist in hospital standardization by using similar methods in caring for clinical records. The results of this organization have been an improvement in the classification of disease, the attainment of a closer cooperation with the hospital staff, the bringing about of a more nearly similar annual report, the extension of membership to ten other hospitals, and a keener study of the whole problem of collecting and publishing statistics.

The National Tuberculosis Association has for the past three years been studying and perfecting a standard nomenclature and standard follow-up system which will be reported for adoption by all members of the association this year.

The need of common standards is clear; the appreciation of this need is shown by these two widely separated considerations of the subject. The exact method by which we may attain this standardization is, however, not so clear. Two methods present:

The first, following the lead of the National Tuberculosis Association, by the appointment of a committee representative of the whole country, to consider, compile and recommend, standard tables suited to the several groups of hospitals. Such a committee should consider what data could be collected in common by all hospitals, what arrangement should be made, and what should be published. All data collected should not be published. Statistics for statistics' sake are useless. Some useful purpose must be served before hospitals will finance the publication of statistics. Consideration of the various groups of hospitals should lead to the selection of a different standard of publication. Some data should be common to all and published by even the smallest hospitals. Larger hospitals should publish more complete tables and special hospitals their own special data, but all upon a common basis. What this data should be and what tables should be published should form the work for such a committee. The recommendations of the committee should then be referred to the hospitals through their executives for consultation with their staffs. As has been pointed out, hospital statistics concern both staff and administration. It is a subject needing the sympathetic and careful study of both the physician and superintendent. Neither group should seek to impose its ideas upon the other without consultation.

The second method would be the consideration of the same subject by geographical units, committees representing such units while covering the same ground and confronted by the same problems, might be influenced and guided by local conditions so as to produce a plan that would meet with more sympathetic reception. Since both staff and executives are represented to a large extent in the state medical societies of the American Medical Association, the subject of statistics and their publication might well be submitted to these societies for their consideration. Conversant with local conditions, dealing with a smaller and less complex situation, they might work out a system that would be more likely to be adopted by the hospitals of their area, than a more ambitious and comprehensive plan which ignores these local conditions. If such local systems should meet with adoption, comparison of the success of various plans could be made and larger grouping result through the adoption of the better plans and perhaps finally a common system adopted throughout the country.

Of these two plans, I am inclined toward the support of the first, as more likely to produce results.

CHAIRMAN BACHMEYER: Dr. Faxon's paper is now before you for discussion.

DR. HOWLAND: I should like to move that this section recommend to the Association the assignment to an existing committee or the appointment of a special committee to work out a standard annual report, establishing definite standards, as has been done by the committee on forms.

(Motion seconded and adopted.)

CHAIRMAN BACHMEYER: I will ask Dr. Parnell to take the Chair to hear the report of the committee of which I was appointed chairman.

This lengthy report has since been printed and distributed, so not included here.

DR. FAXON: Last night we received one of the portfolios and went through it. Dr. Howland and I think the Association should thank the committee for the immense amount of work they put in on this and the very clear, comprehensive and usable report that they have submitted.

MR. CHAPMAN: 161 forms may scare you, but I want to assure you that there is not a single form in this system of recording that is not absolutely pertinent to efficient hospital operation, and I do not qualify that statement even for a ten bed hospital. The trouble with our hospitals is that we have not known what we have done, or judging from the reports and forms we have gotten from other hospitals, we have known too much about what we have done. If you will get this down on a basis of principle, not discussing the individual forms, because there are lots of mistakes in them we know, but if you will think of this set of forms, think of the principle involved in setting up this scheme, and discuss it on that basis, and that basis only, I believe the product of the committee's work is going to rebound to the very material benefit of the hospitals of the country as a whole, and if we have done that, I think we will all be satisfied.

CHAIRMAN PARNELL: I think we would like to hear from Dr. Bresnahan, the other member of the committee.

DR. BRESNAHAN: Look at that portfolio. It looks rather formidable, but if any hospital superintendent will go home and collect one of every form used in his hospital and put them in a pile, he will be astonished. None of us recognize how many forms we actually use because we get them at intervals, but collect one page from each of the



forms used in the operating room, in the store, in all the departments, and then add those you have mimeographed and typewritten, put them in a pile, and you will be astonished at the number of forms used in your hospital today with no correlated system. This is a system that is correlated; one cog fits into another. It is designed to be foolproof. We want to know where we are wrong. For example, the two suggestions Dr. Howland made this afternoon about following up patients. Those items ought to go on that first sheet, the permanent business address and the name of the doctor who brought in the case. The next thing is it has been suggested that we codify the store supplies and that we adopt requisition by code with a key. That could be worked out with this system and not interfere with it at all. This is an elastic scheme and can be added to at any time. At the next meeting of the Association those changes can be brought up for inclusion in the scheme.

CHAIRMAN PARNELL: I think it is too late to enter into a general discussion of the report of the committee and we will reserve that until this evening. Dr. Bachmeyer, do you wish to close the discussion?

DR. BACHMEYER: I have nothing to add, except that the committee has devoted a good bit of the time to the report and has asked to be continued for another year. It is our desire to have a full discussion this evening. We do not believe that this is the best set of forms ever devised, that is not the idea at all, we are trying to present a basis for future development. We want the Association to adopt the report as a basis from which we may build rather than to have another Association or Organization, be it the College of Surgeons, or the College of Accountants, come to us in three or four years and say "This is the way you must do it." We want to get in on the ground floor and have our Hospital Association say "This is the way it should be done or these are the principles that should be applied." Whether your form has one, two or three columns on it does not matter if you carry out the principles and that is what we are trying to give you. We would like to have you go to the registration desk and get a copy of this report. The thousand copies that have come down only weigh about a ton, so it is rather difficult to distribute them in the meeting. We would like to have you get copies and bring them into the meeting this evening prepared for a real, live discussion, suggestions, criticisms, questions or anything you have to offer, so that we

will know something more about the work before we present it to the general session tomorrow night for adoption.

SECRETARY WARNER: We want those reports approved. This does not mean that you think it is absolutely the final word in accounting, but it gives my office, the office of the Association, authority to send them out bearing the approval of the Association, and it is our experience that when things so go out that the psychological effect is that it becomes an obligation to the one receiving it, either to adopt it or to produce something better. They may produce something better for their needs, but oftener they adopt it. One thing more—the amount of work represented by the report was possible only because of fortunate circumstances. Dr. Bachmeyer was willing to work like a horse and able to work the two other fellows almost as hard. The other factor that made the thing possible was the fact that there is in Cincinnati a firm engaged in this line of work, and they have given him the fullest cooperation in the form of information and in the form of technical assistance.

The meeting then adjourned.

## SECTION ON SOCIAL SERVICE.

Assembly Hall, West Baden, Ind.

September 14, 1921, 8 P.M.

The meeting was called to order by the Chairman, Ruth C. Emerson, Secretary of the American Association of Hospital Social Service Workers, Washington, D. C.

MISS EMERSON: I am going to read to you a part of the report of the American Hospital Association, Special Committee, making a survey of Hospital Social Service. This gives the background and is the basis of hospital social service in relation to the medical care of the patient.

"The basis of hospital social service is its relation to the medical care of the patient. The restoration and maintenance of health depends in many instances not only on care, diagnosis and direct medical treatment of pathological conditions of the body, but also upon dealing with the patient's personality and upon the alterations or adjustment of his home conditions, occupation, habits and community relations. The wise physician understands the connection of social and medical elements and seeks a knowledge of both before determining his final program of treatment. The social worker is called upon to secure facts and to aid in interpreting them, in order to provide a basis for a plan of treatment, which takes into account both the medical and the social elements. The social worker also aids in the carrying out of treatment. The merging of the social work with the medical work is essential to effective use of the social workers."

I will introduce Mr. Hochhauser, who is with us to talk to us in connection with the work of the Altro, showing the things which are being done under his superintendence for a number of patients who are continuously, almost, patients of the dispensary or the hospital. After the discussion we will have a paper on hospital social service as it relates to the administration of dispensaries.

MR. HOCHHAUSER: Mr. Chairman, ladies and gentlemen: Care of the sick, particularly the chronically sick, suffering from chronic diseases, to be really effective, must be carried to fruition. If we are really to get results, we must carry the patient on to the time when he can be restored to the community as partially or com-

pletely self-supporting. What is happening in many instances is that admittedly self-respecting sick men and women are turned out of institutions to be loafers. Dr. Bresnahan, in an informal discussion of what can be done with tuberculosis patients, said that he had to be convinced that you could take a man who had tuberculosis, was really sick, and actually diagnosed, and return that man to partial or complete self-support. Of course, there is some basis for that doubt when you remember that Dr. Baldwin of Saranac estimates the number of relapses as high as sixty per cent. In a study we made back in 1909 and 1910; among patients that were discharged from the sanatorium as improved or better, 45 to 50 per cent were worse or dead within six months to a year and a half. Was this tremendous loss necessary was the question we asked when we started an experiment the latter part of 1912. One real problem was that of finding a job that was suitable to the condition of the patient after he was discharged from the hospital or sanatorium. What happens to a patient the first two years or within three years after his discharge from the institution decides if that man is to carry on and hold his own. We tried to get jobs in ordinary industries and we found we were handicapped. The concerns would give all kinds of excuses for not wanting to give employment to these people. We realize that if he was to be provided with work in accordance with the health and strength of the patient, we would have to start a factory of our own where the doctor would really be the boss and where his instructions as to the hours and kind of work could be carried out. We have a time clock at this factory of ours, and the purpose of the time clock is to see that no worker works too long or contrary to the doctor's orders. This work is carefully guarded over a period of years. The patient is examined periodically from once a week up to once in three months. We are interested in the family, because we realize that in tuberculosis, more than in any other disease, you can not deal with the patient unless you deal with the family, so we provide that the entire family would have the necessary supervision. Very early in our plans we realized that the patient would look upon this scheme with suspicion, and we decided that as the man worked and earned any money he would have more. If a man with three or four children, who was receiving ten dollars a week as a relief allowance, and he began earning four or five dollars a week, the relief would be reduced proportionately

so that he would have 12 or 13 dollars. There is no question but what pauperism is in many instances due to inadequate aid. We find that our patients are often prejudiced against working at our factory; they have been told that the thing they must not do is to work indoors, yet we find them looking for indoor jobs and in many instances, anxious to start in some business that would keep him indoors. We have been running this factory now for about seven years. Among our workers, we have not only tuberculosis patients in all stages of the disease, but we have cardiacs and some orthopedic cases. We have had one man with both legs amputated.

We realize that we must try to raise the morale of our patients and have due regard for their self-respect. We do not want our neighbors to know we are a charitable enterprise. That is why in running this factory for over seven years, we have used a style name. It is called the Altro Manufacturing Company. In selecting the kind of work to be undertaken by a patient, it is desirable to select an occupation that offers the possibility of a living wage. In our factory we have a department for making hospital garments for doctors, nurses and patients, these garments being sold at cost price.

THE CHAIRMAN: Miss Janet Thornton, member of staff, Committee on Dispensary Development, New York City, has prepared a paper on "Hospital social service as it relates to the administration of dispensaries." This will be read by Miss Cannon, of the American Hospital Association, Committee on Training for social work.

MISS CANNON: Ladies and gentlemen, I bring you the expression of Miss Thornton's sincere regret that she cannot be here in person to represent this paper this evening. The main reason why she cannot is that it happens to be very important for her just at this time to be putting into practice some of the principles she has expressed here.

That hospitals and dispensaries exist for the sake of the health of human beings is a commonplace of our faith. Whatever emphasis may fall on particular aspects of their work—such as teaching, research, general and special practice—their great and ultimate purpose is care of the community's health. It is, therefore, the requirements of community health that must determine the essential elements in structure and function of hospital ward or clinic. Fundamental to such conception of health is a thought that health is a dynamic rather than a static process,

a condition to be in large measure acquired and achieved. (a) by securing things known to be physiological and psychological necessities, e.g., food, oxygen, sleep movement, warmth, pleasing occupation, companions, obligations; (b) by avoiding things known to be detrimental, e.g., microscopic organisms of various kinds, excesses and errors in foods, over-fatigue, prolonged exposure to heat and cold, thwarted desires and balked energies.

The second thought fundamental to present day conception of health is this—that health is the common interest of all. ‘Typhus fever in Poland is our menace as well as the Poles’. Tuberculosis is passed from servant to master. The breakdown of the family of the injured or exploited worker becomes the burden—and shame—of the community. Care of the community’s health means care of all the members.

The third thought fundamental to present day conception of health follows as logical sequence from one and two, viz., that the care of health is a cooperative endeavor. It is neither the privilege of the wealthy, nor the beneficent gift of the wealthy to the poor. It is rather the prime interest of all that it become the possession by right of all.

These three propositions, health to be won, health the common interest of all, health and cooperative endeavor, compel our recognition and assent as self-evident and incontrovertible. And once granting them assent, they lead us a long way—we pass beyond the old hospital of charitable foundation with its limited care for the very few and usually the unfortunate—and face out to a great enlargement of the field of medicine. For medicine has been enlarging in recent decades in quick response to developments in the great underlying sciences upon which it grows—physical, psychological, and social. And as the sciences generate more and greater power to serve, more and greater demands are made upon the medical practitioner for public or communal service, while to hospital and dispensary administrators falls the problem of enlarging and adapting plant, equipment and service to suffice for the demands of modern scientific medicine.

It so happens that most of what we have learned of hospitals and dispensaries has been taught us by administrators of large, complex institutions, where differentiation of function is great and easily becomes rigid, often becomes rigid before functional relationships have been well defined. And yet the original elements in struc-



ture and function are not very difficult to find or to comprehend, if we approach the subject with open mind. The demands as they relate to plant and equipment have been frequently discussed and well defined. Concerning operating personnel or what we might call service department, classification and functions or activities have not, it seems to me, been so well standardized. Now consideration of this service department and its functions is vital to the subject under discussion—the place of social service in hospital and dispensary administration—because social service, rightly understood and practiced, is an integral and specialized part of the hospital's medical service. It is not a generalized hospital service; neither is it a generalized community service injected from without, nor a graciousness contributed by a ladies' committee.

It happens, too, that hospital social service has originated in old, complex, and much organized institutions—Massachusetts General Hospital, Bellevue, Cook County—and has had to face manifold difficulties of adaptation and has followed many leaders in misleading ways. The most frequent and dangerous pitfall has been the attempt to make up for the many inadequacies of hospital management in other divisions of the service department—housekeeping, clerical, financial, nursing, etc.; meanwhile neglecting its own proper and magnificent service, and worse still, obscuring its vision so that it fails to recognize its own place and tries by mere verbalism to appropriate all manner of heterogeneous activities. Yet withal no one knows better or more painfully than the hospital social worker that the kind and amount of every service, social, clerical, administrative, to supplement the physician, so far recognized as adequate by even the best hospital administrators, is very far from adequate to meet the demands of modern medicine.

How may we reach definition and proper coordination of these hospital activities? Will a study of the activities of clinic and ward yield us facts on which to base definition and proper coordination? I feel sure that such a study is one way to the light, and I propose, therefore, to give a somewhat roughly classified list of activities, and thereupon to endeavor to show how self-evident it is that many activities supposed to be social are not social, and conversely, that many not supposed to be social are social.

#### *I. Government of Institution.*

Adoption of aims and objects; creation and direction

of policies; appointment of operating personnel; responsibility for product and output of work, for publicity or accounting for stewardship, for general financial management.

II. *Upkeep and Operation of Building.*

III. *Selection, Storage, Distribution, Care of Equipment, viz., furnishings; office and medical appliances and supplies; sterilization and preparation of medical instruments, treatment materials, etc.; care of records, histories, charts, indexes, etc.*

IV. *Collection and Disbursement of an Accounting for Funds or Moneys.*

V. *Management of Patients* (in respect to body and person of patients).

1. Preliminary or subsidiary to medical work proper and relative to direction and oversight of patients in clinic or ward.
  - a. Registration or securing and recording identifying data.
  - b. Classification, social, medical, for assignment to suitable ward or clinic or other medical resources and as to eligibility and proper assessment.
  - c. Collection of fees.
  - d. Routing.
  - e. Maintaining discipline and morale.
2. Relating to medical work proper:
  - a. Medical (social) investigation and study of each patient.
    1. Learning what the patient complains of or believes to be the matter.
    2. Observation of patient and his circumstances; from one particular part affected all the way to complete study of organs, systems, functions—with little or much of exact testing (laboratory or other) and little or much of search and insight into personal, social environmental conditions. (Objective symptoms.)
    3. Securing from the patient or others familiar with him (as parent with child) a history of relevant circumstances and events in the patient's life, which may consist of no more than a brief statement of circumstances and events immediately associated with complaint, or may be expanded into an illuminating biography covering

heredity; development and environmental conditions.

4. On ground-work of evidence afforded by the above processes (1, 2, 3) formulation and statement of the medical (social) problem. (Diagnosis.)
- b. Selection and application of remedial measures for medical (social) problem. (Therapy).
  1. Interference with bodily conditions:  
Surgical,  
Chemical (drugs, etc.),  
Bacteriological (vaccines, serums),  
Mechanical (Massage, manipulation, supports, etc.),  
Electrical,  
Radium, x-ray and other ray therapy,  
Bio-chemical (foods, gland secretions).
  2. Control of Environment:  
Protection so that natural defenses of the body may work at best advantage, e.g., rest in bed,  
Adjustment and change, e.g., working conditions, recreational opportunities, sanitation, etc.
  3. Regulation or change of habits of life and thought, e.g., diet, exercise, apprehensiveness, temper, etc. (Health education of both patient and his community may be included here.)
- c. Recording medical (social investigation and treatment).
- d. Analyzing, testing, measuring work done in management of patient. (Statistics.)

A similar listing and classifying might be attempted for hospital relationships covering such topics as convalescent care, public health nursing, schools, courts, hazards and hardships of industry, etc., under a heading "Community Relationships" or of cooperation among divisions of the medical work proper, and administrative control of divisions, etc., etc., and the attempt would yield enlightenment and direction. There is not space for it in a paper of this kind, for it still remains to be shown what in the above list of activities is social in the technical sense of hospital social service and what is not. Furthermore it must be shown how broadly social in a non-technical sense (and the distinction between technical and non-technical or non-medical here is most important), almost all hospital matters are, because inextricably related to community needs. Every item under Section I, "Government of Institution," has social bearing in the

non-technical sense, but not one in the immediate responsibility of technical hospital social service proper. Hospital social service has the obligation of supplying trustworthy data and interpreting it to those who are responsible for the governing function, and, therefore, it is obligated to keep correct documents and render correct account of its work.

Furthermore, hospital social service is not directly concerned in any way with Section II, "Upkeep and Operation of Building or Plant," nor with Section III, "Selection, Storage, Distribution, Care of Equipment," nor with Section IV, "Collection and Disbursement of and Accounting for Funds." Hospital social workers may reply that they do nevertheless perform sundry functions under each of the four headings. I myself have done so, but styling myself a hospital social worker and then performing certain acts does not necessarily render those acts social in nature. The verbalistic habit of mind which allows us to describe all the professional acts of a person in accordance with an assumed professional character is easily seen to be absurd as soon as expressed; but is there a hospital in the country that is not describing some housekeeping or social function as nursing because performed by a nurse, some business or clerical function social because performed by a social worker? Like many another intellectual fallacy, its absurdity does not reduce its power for evil.

Not until we reach Section V, "Management of Patients," do we find the activities for which hospital social service is immediately responsible and here, too, there is the interweaving of several functions. Taking up the activities one by one, "Registration or the securing and recording of identifying data" is plainly clerical in nature. Appreciation of social values, however, makes the clerk realize the importance of this activity, enables him to sense and secure the accurate data, and greatly increases his speed and accuracy by virtue of skill in making contacts with people. Yet registration is not a function of hospital social service. "Classification of applicants as to their eligibility for admission, as to proper assessment of fees, and for assignment to suitable ward or clinic," here for the first time the medical function proper comes into play in securing medical data for proper assignment, and also for the first time the medical-social function in correlating the applicant's medical need, the cost of medical treatment for same, his resources and his obligations.

"Collection of fees and routing," c and d, may be briefly described as business or administrative and not medical-social. "Maintaining discipline and morale," e, is obviously social in character. It is the kind of social service, however, that is required in schools, factories, etc.,—when-ever, indeed, groups of people are managed—and is not, I believe, specifically medical-social.

On the other hand, it is plain from the mere rehearsal that the second group of activities under Section V, those relating to medical work proper, contain much that is medical-social. Will it surprise many physicians to be told that much they do is medical-social service? I believe not, though few perhaps ever stopped doing long enough to think the matter out. Most will grant (1) that eliciting from the patient what he complains of or believes to be the trouble is not just a matter of anatomy or physiology, but is also winning of confidence, understanding a personality, etc., and that these last activities are in essence social; (2) that the actual physical examination of the patient requires a technic that is not in essence social, though even here a sympathy with the patient's temperament or rhythm seems to make a strange difference. "The search and insight into personal, social and environmental conditions" is strictly social. (3) Lastly, "Securing from the patient or others familiar with him a history of relevant circumstances or events in the patient's life," is unquestionably a major part in social functioning. It may be concluded, then, that in reaching almost any complete medical diagnosis, social aspects have been considered as causative factors, and some social functioning has revealed the patient.

Passing on to medical treatment, the importance of understanding and managing the personal, social, economic situation of the patient becomes still greater. It is of minor importance in the actual "interference with bodily condition" (Process 1). It is undeniably of major importance in "Control of environment" (Process 2), and "Regulation or change of habits of life and thought" (Process 3). Many illustrations can be brought forward to show that in medical practice of the most tested and standard kind, regulation and re-education of the patient, accompanied by removal of strains from without, constitute almost the whole of treatment; and here again the mere rehearsal of the processes of treatment suggests the importance of social service.

May it therefore, not be finally concluded that a very considerable part of the practice of medicine has to do with the personal and social life of the patient, much of it with the intimate, often humdrum affairs of every day, and that it is, therefore, right and proper to say that the practice of medicine is to a considerable extent social service?

The thought that medicine should concern itself with these things is not new; the intention to systematize and organize hospital procedures, so that full consideration shall be given to all social factors relevant to the medical problems of patients, is new or at least so new that a practical procedure for serving all patients rather than few is only just being worked out. The procedure requires that cognizance be taken of the personal and social as well as the strictly medical conditions and needs of all patients from the moment of application to the hospital, and that the patients shall feel that their individual needs will receive the special care which may be necessary. Social as well as medical record is kept of each case, so that the physician has complete data at hand when summing up for diagnosis and treatment. It is the task of the specialist in social work, collaborating with the physician, to correlate the medical plan with the circumstances of the patient's life and make necessary adjustments.

The general policy pursued is to make the patient a partner in the conduct of his medical care, up to the limit of his understanding, appealing to his intelligence and giving him something to do, and having him do all he can for himself. To follow this procedure it is necessary for the doctor or social worker to tell the patient a good deal about his malady, and to outline at least roughly the plan of treatment, especially as to probable duration and immediate steps to be taken. Furthermore it is desirable and all but necessary to review in detail the relationship of the plan of treatment and the patient's particular plan of life. The mere fact of assisting into clear consciousness all factors of a patient's case, be they helps or hindrances, contributes much toward the solution of his problem. It has been demonstrated that this process of analysis alone gives a fairly high percentage of achievement among people of good intelligence and character, where, without it, among the same people, the percentage is low. Careful talking out, point by point, of each item of the plan, is a great help in getting the patient to



understand and see his way clear to carry out the plan. For instance, the medical plan may require the patient to return for treatment two or three times a week over a period of several weeks, or it may require the patient to carry out at home at regular times, certain procedures, such as irrigation, special feeding, rest periods. To adapt or change the day's routine to these therapeutic measures may well call for thoughtful management and sustained effort.

The social worker makes concise entries on a social card of the doctor's recommendations and arrangement for appointments. This card is filed in calendar index under the date of the next appointment and from day to day as the case proceeds. If the patient fails to keep his appointment a letter is sent him, or in more serious cases a visit is paid to remind him and to recall very briefly the plan and instructions talked over with him. The distinction between the interpretative manner of procedure here attempted and a purely mechanical "follow-up" not founded on mutual understanding between patient and hospital is of the utmost importance. Much misunderstanding of the true place and need of the social function in medical work has arisen from describing the mere clerical communication with patients regarding appointments as social work. And whereas the adoption of mechanical devices for follow-up seemed a first step toward social work in some instances, the continued supervision in a mechanical manner only, now appears to me almost more detrimental than absence of supervision, since by missing the main point of social service in hospital work, the very heart of it—interpretation—it deceives those who practice it and those who support it and thus retards the ultimate socialization of the clinic.

Where obstacles for treatment arise greater than the patient can handle unaided, the social worker must decide what resource in the community can give the needed assistance. For example, a district nurse will be asked to watch the temperature and pulse, or give an enema; a vehicle will be secured to bring the sick, old, crippled, or a mother with several small children, etc., back to the hospital; while a few cases will be discovered to need intensive investigation outside the clinic or ward, and organization of extensive relief and corrective measures.

Analysis and classification of the staff or personnel to execute all the activities and procedures above studied can

be made to look very simple on paper. In fact, it seems not possible to make more than three big divisions, viz.:

- (1) Medical staff,
- (2) Assistants or aides to the medical staff,
- (3) Administrative staff, together with a governing body, and chief executive or superintendent. Hospital social workers, together with technicians and clerical workers, take their place in Division 2 as assistants to the medical staff. Unless the functions of the three personnel groups are rightly defined, confusion must result. Having defined the functions and learned the technic for their performance, there is no intrinsic reason why one person may not perform many functions. In small institutions, neighborhood clinics for instance, it is often necessary that the executive should fulfill the duties of administration, clerical, nursing, social service and others. Similarly, physicians are many times called on to play the rôle of friend, business adviser, social worker, nurse, etc., as well as practitioner of several medical specialties.

It may often happen that the social worker in the hospital may be called upon to do things that are not technically hospital social service. Social workers given administrative charge of clinics, for instance, must perform or supervise much clerical work, often business details and even housekeeping matters. The combination of responsibilities is reasonable and it is for the social worker to see to it that she has assistants enough so that the most important responsibility assigned her, viz.: the social service, shall not be neglected. For the social worker must ever bear in mind that the personality of the patient must be reckoned with in nearly all medical processes except those within the laboratory; that the study of character and behavior, the efforts to change habits of thought and behavior, to control environment or in general the social aspects of medicine, are today not usually performed in the systematic, scientific manner of the other more standardized processes of medical work.

Yet a survey of the activities of medical service shows the presence and importance of these elements. If patients are to win health, if the health interests of the community are to be advanced and safeguarded, the social aspects of medicine must be more deeply studied and more skillfully practiced.

MR. RANSOM: Ladies and gentlemen, in discussing very briefly Miss Thornton's paper, I will try to discuss it from the angle of the administration of a dispensary. I think

one would hardly be expected to discuss the great practical phases of social service—what Miss Thornton chooses to define as the actual social service task—the actual task of the social service department. To my mind, the product of the hospital is the important thing, not its processes. What is the product of the medical institution, and what should be the product of the medical institution? It seems to me that it should be a certain amount of assistance to sick people on the road to health. It should be for those who are going to travel that road, and as far as possible decide what degree of disability that person is going to have after he leaves the hospital. The product of the hospital is not discoverable. The product of the dispensary is not discoverable primarily in the institution itself, any more than the product of the public school is to be found in the school room; it is out in the community, and it becomes part of the function of the medical institution to help make secure and effective the patient for the community, gaining the good work, the important result of the medical work of the medical institution. It seems to me that this is the particular function of the hospital in the community, and it is in this connection that the social service has its great place. To make a very homely illustration, I can imagine a surgical dispensary putting on a very fine looking bandage onto some patient, which bandage did not last until the patient got very far away from a medical institution. Now, in a measure much of the good work that is done in the hospital, unless there is some way of helping a patient himself in his somewhat changed living, which he must have after his illness, or his disability, unless there is some way of helping him make the readjustment, much is lost to the patient and to the community, and it is to my mind there is where a large part of the value of social service lies.

MR. DANIEL TEST: We are here discussing a very important arm of the hospital service, and I feel the membership should be well represented. Those of us who have to do with the getting of service have no doubt about the importance of the social service work in the hospital, and personally I do not feel a bit afraid of the social worker. I have heard it said that the Hospital Service Department was trying to wag the dog; I do not think that is so. I think the social service workers have often times over-estimated their importance—the importance of their hospital work. I do not think they are responsible

for it and I think they have gotten over it. We made a big fuss about our work in the field and why should not the social workers have their share of the praise also? I do want to testify to their great help and satisfaction that our social service has been to me individually and to the hospital organization.

DR. MACEACHERN: I believe we hospital superintendents should express ourselves on this subject, because we realize full well that the scientific success in the care and treatment of the patient depends to a very large extent on all that goes to make up the social circumstances of the patient. We have watched with pleasure the rapid development of hospital social service departments from that of charity dispensing institutions to well organized scientific methods for the proper study and investigation of conditions which may be remedied, leading eventually to prevention of disease and education of the public, as well as assisting materially in hastening the recovery and convalescence of many afflicted patients. The actively carrying on of all such work in any hospital means less illness, less wastage, less loss and consequent adding to the national wealth of the country. It is needless to say that every hospital should recognize this work and carry it on, whether on a large or small scale; indeed, it is just as necessary as any of the scientific departments.

We have had a rather different experience in the development of hospital social service in our city than probably some of you and is carried on today perhaps much differently than that where it is more highly developed in such cities as Boston, Cleveland, Montreal, Toronto, etc. We are running our department in a thousand bed hospital with a few highly trained workers, but utilizing all existing organizations outside to assist in the work. A year or two ago I called together all the organizations in the city and surrounding municipalities who were doing either public health or welfare work, and we formed an association known as The Greater Vancouver Public Health and Welfare Association. The main object of such an organization was to promote cooperation and eliminate overlapping or omission. A monthly meeting is held at which one or other of the organizations presents the work which they are carrying on. This is followed by a round table, acting often, as a clearing house between the different organizations in their difficulties. At present the establishing of a Central Bureau of Information is being worked out. The Association has been the means of a

better understanding between all, so that in our own particular case of hospital social service we are able to utilize the various organizations outside to help us materially in our work. Probably this is the natural evolution of a well developed department such as I have referred to, but we found ourselves surrounded by voluntary and other organizations well established in the work, and we found that in order to succeed with efficiency and economy we would have to work in with them and it was advisable that they should work in with us. The scheme is, therefore, working out very nicely.

Our Social Service Department has complete charge of the management of the Out-patient Department and follows the cases throughout the clinics and afterwards. Our nurses-in-training take their turn in this department and acquire a certain amount of knowledge regarding social conditions, which helps them materially in their training. During the summer, for several weeks, the Social Service Department is able to run a summer camp, where a large number of the women and children patients of the hospital can go, which otherwise it would be impossible for them to secure. While there are numerous other features which I would like to elaborate on, the evening is now well spent, but before concluding I want to mention one particular phase of work which we have to deal with in our City, and I suppose all other cities are alike in this—we have a number of illegitimate children born in the hospital, and while we insist that they should be breast fed and taken care of by the mother while in, we find that owing to economic, social and other conditions, there is need of finding good homes for these babies afterwards; consequently any babies to adopt are handled through the Social Service Department of our institution. It means the placing of six or eight babies a month in excellent homes, whereas otherwise they might be more or less neglected and eventually become a burden on the City. While it is our endeavor to encourage as far as possible the mother to take care of the baby and raise it, at the same time many of these cases must be taken care of and I know of no better way than through the Social Service Department. Finally, I feel that this department is such an assistance and comfort to the administrator that it should have his full support and should be always utilized whenever an opening occurs.

Thereupon the meeting adjourned.

## ROUND TABLE ON HOSPITAL ADMINISTRATION

September 14, 1921, 8 P. M.

Dr. A. C. Bachmeyer in the Chair

CHAIRMAN BACHMEYER: A word of explanation will probably be in order before we begin our program. This afternoon when this report was presented, I asked you to take copies of it and be prepared this evening for discussion. We have about forty-seven minutes before this session must be closed and desire to devote a part of this time, to the conclusion of the business of the section. That will consist of the election of officers.

Before beginning the discussion, I would like to ask whether there are any in the audience who did not get copies but who would like to have copies of this report now. (About two dozen members held up their hands.)

You probably have inferred that the Committee that prepared this report was not a one man Committee, and I have asked the other two members of the Committee to take their places on the platform this evening, in order that they may assist in the discussion or answer questions that may be propounded.

We might, in order to stimulate discussion, consider the report by sections and call your attention to the introduction of each of the groups.

The accounting group, (as I said this afternoon) recognizes two basic divisions, the recording of capital income and expense, (corporation accounts) and the recording of operating income and expense (operating accounts). We have not endeavored to define or to enlarge upon the capital accounts, because they vary so greatly in individual hospitals.

The operating accounts, we have endeavored to define, in the "income accounts" have set up a journal system and a cash book. You will notice that under "cash book" we explain that the system is based upon the necessity of noting the distribution of cash at the time of its receipt. The receipts are apportioned or tabulated according to one of two schemes as shown under the chart of accounts. The first scheme provides for the division between pay and part-pay patients. All cash, as it is received, will be distributed, and will be shown to have come either from full pay or part pay patients. The other



scheme provides for distribution according to the various special services; that is, from the board of patients, and from the charges that are made for the use of the operating room, delivery room X-ray laboratory, drugs, dressings, telephone, telegraph, etc.

In the expense accounts we have cash book, voucher register and expense distribution. The expense distribution will be made on the basis of accounts as shown under accounts Nos. 400 to 500, in the chart of accounts, and distinguishes between the administrative department; the housekeeping department; the laundry; power plant, heat, light and power expenses; maintenance and repair of buildings, maintenance of grounds, garage (motor service), nurses' home, etc., and the professional care of patients, enumerating under this item nursing, pharmacy, medical and surgical supplies, medical services, anesthesia, X-ray, special therapy, (which may be classified according to your own needs) and laboratory services. Then the commissary, dietary and social service department. All these items, from administration to and including the social service department, will be used to make up the total operating expense and that total should be used, when determining the per capita per diem cost; dividing into that total the total number of treatment days given. The expense of the out-patient department can be handled in the same way in computing the average per visit cost in that department.

The next form under accounting is the petty cash memo, (the sixth form in the portfolio). If an expenditure of five cents or twenty-five cents, etc., is made, one of these memos should be made and when the petty cash fund is reimbursed, these little slips should be used as the supporting evidence to the voucher.

There are several methods of handling payroll accounts. There is submitted a system for the payment of all salaries and wages by means of checks under one voucher number, the voucher to be in detail and regularly drawn upon an amount which is deposited in a separate payroll account in order to facilitate balancing payroll items; Under supplementary accounting forms another system of preparing the payroll and paying in cash is shown. The next forms pertain to the patients' accounts, and instead of having special slips come in from every department and increase the cost of stationery, we have recommended one form for special charges, (one such report to be originated daily by each department head). That

is the head nurse on the ward, (if the nurse in charge of a nursing unit is the one who is to submit the special charges for patients in her unit), would each day send one or more of these forms to the cashier for posting to the patients' ledger, (the same applies to the X-ray department, the laboratory and any other department which makes special charges). There are 161 forms in this portfolio, if we had endeavored to include every form sent to the committee, there would be over 500 in the report and a study of your stationery in connection with this report will, I believe, enable you to see where you can eliminate a number of them.

The next accounting form has to do with the equipment inventory. I doubt whether there are very many hospitals that have a record of their equipment, at least there were very few equipment inventory forms submitted. Hospital equipment moves about, and I doubt whether there are very many superintendents who have in their offices or accounting division a record that will tell them how many beds they really have in the hospital or how many chairs or how many tables, and if the hospital were destroyed by fire, they would probably have some difficulty in showing an insurance company what equipment there had been in the hospital. The equipment inventory is a record that should be kept and this form enables one to make it quickly and check it at intervals.

A budget form is submitted for guidance only, because we realize that hospitals operate under varied conditions, and no committee could set up a budget form and say "This is the kind of form to use". The form submitted is a workable one. This concludes the accounting forms, and I would like to hear any discussion or any questions you may care to ask on this subject.

DR. SMITH, of Chicago: What method is introduced to make sure that all charge slips that the nurses should make out will be made out?

CHAIRMAN BACHMEYER: We can provide you the form, but we cannot and no form can assure you that every charge that should be made by any department head is going to be made. I do not know of any way that you are going to get that except by checking up, but that is supervision.

MR. CHAPMAN, of the Mt. Sinai Hospital: May I answer that further? If you will insist upon a special charge sheet coming down every day from every department, irrespective of whether they have a charge to make

or not, (and if they have no charge, marking it no service or no charge), then you will have a greater assurance that you will have all your charges entered. There is one thing I would like to impress upon you folks, and that is this: reading this report in this meeting, you may get the impression that it is elaborate. Now I will admit it is elaborate as compared with the histories or with the financial records some of you are keeping, but I submit without any fear of successful contradiction, that if the average industrial plant kept the type of record that the average hospital keeps, they would go broke in two weeks. I venture the statement that there are not 10 per cent of the hospitals in the United States and Canada that actually know what they are doing financially. Now that is not a statement, in the air, that is made from a fairly thorough knowledge of hospital accounting as it is practiced or as it is. It is true that this elaborates very definitely some of your systems, but, folks, it is as simple a system of financial recording as is possible to get and still have an understanding of what you are doing.

On purchase and issuance the primary thought was that this business of giving orders instead of purchasing material had to be stopped. There is a very definite difference. The trouble with most of us is that we never decide that we want something until we run out, and then the first fellow that we see or the first telephone number that we find, that is where we buy it, and when we do buy it, why, we put it down on a piece of paper, (a bushel of potatoes, and that is all there is to it until the bill comes in) and you have absolutely no check whatever on whether or not the price was \$1.65 or \$1.90 or \$5.00. That produces inefficiency, there is not any question about it, and if you are to buy intelligently—and I say buy, and not give orders—if you are to buy intelligently, you certainly must have a record of what you are doing. First of all is the quotation sheet, and I want to emphasize here that this applies to the small hospital as well as the large hospital. Any administrator of a hospital who buys of one individual without getting quotations from another, in my opinion is not fulfilling his obligation to the community he serves. That may be pretty strong talk, but I think it is pretty near the facts. The quotation sheet is designed in as simple a form as possible to get comparative bids; that is all there is to it; what you do with it afterwards is a matter of small moment.

Then the purchase order is given as a definite check to the hospital personnel as to what has been done by the buyer and as an indication to the vendor of merchandise that you are on to your job and know what he has sent to you, that you know what terms he made and that there won't be any misquotation either wilful or by the human element, and that the hospital will be assured of getting the commodity they buy under the specifications and under the terms that they buy. It is practically self-explanatory.

The next is the receipt for goods. I can take you to a great many hospitals, and I would want no better graft than to be the steward in those hospitals. Believe me, I could make more money than I am making as administrator, for the very simple reason that not the slightest effort is made to signify as to the receipt of materials. Now this receipt is a very simple matter. You do not have to have a storekeeper to do it, but whoever is authorized to receipt for your goods and check them certainly should not carry it around in his or her head, they should put it down on a piece of paper, and a copy of the purchase order or a copy of the receipt and the bill or invoice that is sent should be checked one against the other, and those three form an integral part of the payment voucher, and no payment should be made without that supporting evidence of the receipt of the goods and the correctness of the invoice.

The internal requisition is next. You can go into most hospitals and they either do not go through the form of putting it on a piece of paper, or the requisition is a scrap of paper about that long. We have made it just as simple as we could, and we ask as a definite part of this system, that you accept the principle that no one shall get a paper of pins out of the storeroom without the approval of the administrative official or his properly delegated authority. Now this business of the superintendent of nurses having authority to withdraw supplies from the storeroom is absolutely incorrect in principle; the principle of the dietitian being permitted to take foodstuffs out of the storeroom is incorrect. I do not mean to say for a minute that those people are incompetent to say what they want, but I do say that if you make the current supplies or the stock supplies of an institution too available for consumption, you are courting waste, that's all there is to it.

The inventory form is predicated upon the use of the chart of accounts. A great many of your hospitals will

buy a thousand pounds of cotton this month to be used over a period of five or six months. Now it is maintained that the thousand pounds that are bought in July should not be charged into July's operation unless they are used in that month, and it is the thought that by keeping a perpetual inventory—and I want to reiterate here that it does not take much time to do it—by keeping a perpetual inventory and charging into July's operating expense only the consumption of July, you will be able to balance out your performance and analyze the peaks of your performance and the depressions of your performance.

The prescription form is self explanatory. The narcotic record is accepted by usage in a great many institutions. It is practically self explanatory. It is also prescribed, of course, by the Harrison Narcotic Law. The diet order is the only special requisition we have made, because it must pass through an entirely different channel than the ordinary supply requisition. Employee's laundry list is self explanatory.

Purchase register—how many know what is the right time of the year to buy potatoes, and this, that and the other thing? How many know what you paid for cotton this time last year within five percent? Do I miss my guess very materially? And, folks, that is a definite necessity of equipment to anybody who is going to buy intelligently. I do not care how small your performance is, if you are going to do it to the best of your ability, you have got to have these facts before you, before you can buy. If you are satisfied to let some fellow talk you into buying something of which you do not know the true value, don't use this system. If you want to operate your institution to the best possible advantage, you don't have to use this system, but use something like it. The purchase record provides the same general type of information as the purchase register. The gardener's register only applies to those few institutions that operate their own gardens and farms, and the menu list is submitted with the hope that we will get away from the seven days' idea of diet, that have Monday as bean day and Tuesday as pork day and Wednesday as something else, that we will get a greater variety of diet into our institutions by adopting diets on a ten day or some other comparable period, so that we won't know when we are to have these various foods.

REV. STEPHAN, of Columbus, Ohio: I would like to ask

Mr. Chapman for information as to when is the best time to buy potatoes?

(Applause and laughter)

MR. CHAPMAN: I am no prophet or son of a prophet. I can give you the information for Cleveland if you want it.

REV. STEPHAN: Well, I think this question I want to ask now is really better than the other; I would like to know when to buy canned goods?

MR. CHAPMAN: Well, I did not know that this was a dissertation on purchasing. If this form is properly operated, it will record every purchase that you make, and whether or not your price is lower or higher in a given period of time will be reflected in the form, and certainly the best criterion of whether you have made a good purchase is whether or not it is the cheapest you bought during the period of time. Certainly, merely reading this form is not going to give you a commodity index so that you will be able to buy; it is necessary to study your market reports just the same, but I do say that this record, if kept, of all canned goods—you cannot say canned goods, you have to say canned peaches, canned asparagus, etc., have a separate sheet or card for every commodity you purchase—will be of great value to your purchasing agent.

MR. DANIEL TEST, of Philadelphia: I would like some one to tell us what is the proper time to buy anything, but I do not believe that any good buyer would undertake to do it. We cannot buy potatoes at the same time every year and do it intelligently, for potatoes one year will be high one time and not another. In canned goods the market varies with the seasons and the good buyer will use judgment and buy when he feels that the market is best. I say this because I think we are wasting time to talk about when is the right time to buy things.

CHAIRMAN BACHMEYER: I think Mr. Test is right; we are not to have a round table on purchasing; we merely want to make the point that this form is not going to show you anything when you put your first entry on it, but through experience plus market reports, it will give you a background for your action in purchasing various commodities. If Dr. Bresnahan can tell you something about the professional service forms in about three minutes, I will let him have the floor.

DR. BRESNAHAN: Professional forms—we have heard a good deal about in the last few years. The campaign



of the American College of Surgeons has done more than anything else probably to introduce proper forms in hospitals that did not have enough forms or had improper ones. There is no perfect form. We have done our best with these; we have taken thousands of forms from hospitals, looked them over and often failed to find a single form that we could include unchanged. We have had to change and subtract from the various forms we have included under professional forms, in an endeavor to gain what we thought was a better one. All are cut  $8\frac{1}{2} \times 11$  inches so as to save paper and go in the standard filing cabinets most of us have. We have eliminated printing from them where we possibly could do so. To make professional forms correctly, each hospital will have to have some routine of history taking. That depends upon their staff. The staff should get together and decide what they think is a good routine to take history, and then carry that routine out on the forms used. Dr. Bachmeyer remarks that if you print those instructions on the form, they will not fit any one particular hospital and they will be very costly. Not only that, but printing instructions on forms robs the man who is taking the history, very often, of unbiased judgment; he is apt to be biased in following the directions that are printed on the margins of the form. We endeavor to stick as near as possible to a blank sheet of paper, because in the hands of a competent man, a blank sheet of paper can be made into a better history form, in the opinion of the committee, than any other.

MR. CRANE: I am not an accountant or an expert, but I do realize that the work reported here by this committee is the finest ever done by any committee of the American Hospital Association.

CHAIRMAN BACHMEYER: That is not what the committee wants; we want discussion of the report.

MR. CRANE: But if all the members realize the amount of work done to assemble this material, I think undoubtedly they will put it to good use.

DR. TANNENBAUM, of Philadelphia: I would like to ask the previous speaker why he thinks a blank form is better than a form that has headings on it with leading questions for the examiner? In the experience I have had, especially in public health administration, we have always found that putting headings on forms so that the examiner will be able to follow them has given much better results than a form entirely blank.

DR. BRESNAHAN: When you get a heading, the first thing you do is to put down a negative.

DR. TANNENBAUM: But if you have a blank, you do not know whether the examiner has answered the question or not.

DR. BRESNAHAN: But if you put the word "negative" down it does not mean anything to the average examiner, you do not know whether he has listened to it, outlined it, or don't know anything about it. If the form for history taking in your institution prescribes the word "negative", all right, your headings might go, but the scientific world, I do not believe, will countenance the word "negative" in a physical examination.

DR. TANNENBAUM: I think the life insurance companies have about as efficient an organization along that line as anybody, and you will find that all life insurance forms have leading questions, forcing the medical examiner to ask those questions and make some record of the question.

CHAIRMAN BACHMEYER: Let me answer your question. Life insurance companies repeatedly have told me that the reason for that particular form, is that they have no supervision over their men; they are scattered over a tremendous area and cannot be supervised properly and the examinations are sent in by mail to them. Many of the life insurance companies are not satisfied with that particular form, it is the best they have at the present time, but they feel that if they could more closely supervise their physicians, they would not need that particular form.

DR. TANNENBAUM: I would like to know whether the assemblage here tonight think a blank form is an improvement over a form that has leading questions?

CHAIRMAN BACHMEYER: I would like those to raise their hands who prefer the blank form, which bears no directions—those who prefer that to the one with headings. Now I would like to see the hands of those who prefer the form in which the headings and directions are all entered and the examiner says "yes" or "no", or "negative" or "positive". In our judgment the first has it, but it is a mooted question; there are those in favor on both sides, and in such a matter all we can say is "here is the principle, here is something for discussion, something that will probably need further work." I will say this though, that in the matter of economy, which is one of the things we had in mind, there is no argument; when you come to set up the forms, you are going to have a great variety

of special forms, you are going to have some forms, where the questions you ask (particularly in tuberculosis, in diabetes, in acute articular rheumatism, in heart cases) will not apply in other cases; you are going to have a multiplication of forms; you are going to have an increased cost of printing that you do not get with the blank form, but it is a question that will require further study and discussion.

REV. STEPHAN, of Columbus, O.: If you use the blank form, would you not have to depend largely upon the faithfulness and loyalty of your physicians and surgeons to get the history, unless you have it with the headed outline and form? Are you not more likely to get what you want in the way of a history if you have the question form?

MR. SPRINGER: Along with the others, I voted on this question; it seems to me that so far in the discussion everybody has overlooked the only point that is at issue in it. You will vote for a blank form if you have a system in a hospital by which you direct those under you; if you have no system in your hospital by which you direct those under you, but if you have a hit and miss, happy-go-lucky way of doing things, you must have a form with headings that tells them what to do. It seems to me that that is the problem that is involved. It is not a question of loyalty; your men may be ever so loyal, but if they are not instructed as to what should be done, their loyalty may be 100 per cent perfect and you will get bad records.

MR. TALBOT, of St. Louis: First, I want to say that I do think, too, that most excellent work has been done, and the reason I think that is not because of the volume of work they have done, but because they are striving at a point that is extremely vital to hospital work, and that is the standardization of forms. Now with regard to the medical form in which I am especially interested, it seems to me that there is little room for discussion on that, and yet it is germane and I endorse the remarks of the last speaker, for he has very well put what I had in mind to say, and that is this, if your men are trained men in writing histories, there is no form quite so efficient as a blank piece of paper; whereas, if your men do not know how to make an examination and if they do not know how to write a history, you need for them a guide, and I am free to say that many of our splendid men do not know how to write a history, but they are learning, and it is the business of this Association to take back to our homes,

our hospitals and our staffs, the information about what the other fellows are doing, and the time is now here when we must not only write our histories in twenty-four hours, but we must write a comprehensive history and we must have an analysis, a skeleton form in our own minds and not on a piece of paper, whereby we can follow out a definite, well planned examination and record the facts that are germane to the particular patient in question and not clutter up the paper with an abundance of useless things so far as this particular case is concerned.

CHAIRMAN BACHMEYER: I am sorry that we cannot devote more time to this discussion. I would like to call your attention to the last page of the report, to the analysis of Institutional Activity. I believe that very few institutions are analyzing their activities from day to day, and if you will look at the last two "yellow sheet" forms in the book, you will see that one of them provides for the analysis of the vital statistics or professional service work, the number of patients admitted, the number of discharged, the deaths, the operations, the anesthesia, the X-ray, the out-patient, the social service work, etc., and the other form gives an analysis of the domestic performance, dietary department, engine room, laundry, and you can extend that as far as you need; the forms that will give you that information are also here provided.

The last paragraph refers to the use of the graphic charts. We did not feel that we could put those in our recommendations, but we feel that we might say to you that graphic charts are very valuable in showing what you are doing. It is getting on toward nine o'clock; I would like to have any further action or discussion that you care to have within the next few minutes.

EX-PRESIDENT WILSON: I move that this section recommend to the Association that the report of the committee be accepted and the recommendations made in the last two paragraphs of the report, about the committee being continued and the question of future work, be adopted by the Association.

Motion seconded.

DR. MACEACHERN: Is not this question coming up again? You have not all your Association here. We will have time to go into the report when it is presented and taken up tomorrow night. There is another session tonight and a lot of people are away.

CHAIRMAN BACHMEYER: If this motion prevails, it will come before the meeting tomorrow night, (before the

general session,) as a motion duly made and seconded. We cannot adopt anything here tonight. Is there any further discussion? If not, all in favor of Dr. Wilson's motion will say "yes"

The motion was carried.

CHAIRMAN BACHMEYER: The next order of business before we close will be the election of a president and secretary for the section for the ensuing year. I will be glad to entertain nominations for the office as Chairman of this section.

MR. DANIEL TEST: I want to nominate Dr. Bachmeyer as chairman.

CHAIRMAN BACHMEYER: I would like to declare you out of order. It is not customary, neither do I desire to hold office for a second year.

MR. DANIEL TEST: I have no desire to urge it upon you, but it seems to me that it would be a pity to change. At the same time if you do not want it, I will withdraw the nomination, but I think I will make a mistake if I do.

CHAIRMAN BACHMEYER: Well, I hope you will make the mistake.

MR. CHAPMAN: I nominate Dr. Parnell as chairman for the coming year.

The nomination was seconded and carried.

Dr. Fonkalsrud and Dr. Faxon were nominated for secretary, and on a show of hands, Dr. Faxon was elected.

CHAIRMAN BACHMEYER: I declare Dr. Faxon elected secretary for the ensuing year and the session on administrative problems adjourned. Dr. Ransom will take the chair.

## ROUND TABLE ON DISPENSARY PROBLEMS

September 14, 1921, 9.00 P. M.

Mr. John E. Ransom in the Chair

CHAIRMAN RANSOM: The program of this convention has, in a measure, ignored the fact that people cannot be in two places at the same time. I was sorry to meet quite a number of people going out, but possibly they will come back after we get a good live discussion on out-patient problems. I know that those of you who have been coming to the meetings of the American Hospital Association for the last few years have known that one of the most valuable and important parts of the program has been the round tables on certain hospital and dispensary problems, and for many years the round tables were grouped into one, and I remember, I think it was last year, when the session began about noon and the limit was midnight. This is the first year that there has been any separation or defining of these problems, particularly in relation to the dispensary. This round table very naturally will be exactly what you make it. There have been a few subjects suggested, but I would rather reserve those and let the discussion start from the floor. What are the dispensary problems that you would like to have some of the other people here help you in solving? One of the subjects that has been mentioned as one that we might profitably discuss here this evening is the question of whether or not we can have a larger number of complete physical examinations of patients in the out-patient department. Down in our little exhibit on the equipment of venereal disease clinic, we have set up as one of the standards of a model clinic, a complete physical examination of each patient coming into that clinic. (We know that that does not prevail in many genito urinary or other clinics in which syphilis and gonorrhea are treated.) Can some one tell us how it is possible to organize a dispensary so that a larger number of the patients who come into it secure adequate examination? Or possibly discuss the question of whether complete physical examinations—to what extent complete physical examinations are essential or advisable in out-patient work?

DR. HENRY, of St. Louis: I cannot state whether it is practical to give every patient applying at a large



general dispensary a thorough physical examination. It would certainly be ideal to do so. Any one of us who has had the opportunity to follow the work of a dispensary must realize that there is as much reason for a fairly complete physical examination in the dispensary department as there is in private or hospital practice. I think all of us must have seen, for instance, this happen: A patient applies to be treated in a special clinic or he is on his say so and without special examination referred or assigned to a certain clinic. Unless that special clinic is doing very intensive work he may come for considerable time to that special clinic for treatment of some special condition without some other condition for which he requires treatment being discovered. Especially is this liable to occur if the conditions are in no way correlated or interdependent. I really believe a fairly complete physical examination of all dispensary or out-patients is as desirable as the general physical examination insisted on for all hospital patients. I am not prepared to state that it is practical to give each and every patient a thorough physical examination in a large dispensary, but it is the ideal towards which we should strive, allowing that the physical examination may sometimes be rather general.

DR. W. P. MORRILL: I will go a step further than the last speaker; I believe it is more important, probably, in venereal disease than in any other, on account of the impression on the patient. That admission impression made by a thorough physical examination is more liable to hold him to complete treatment than any other one thing, even more than a follow-up, unless it is unusually forceful. In a teaching hospital, the problem is not so difficult. In a non-teaching hospital, I think those of us who have had experience know that the regular dispensary staff will not do it; that is settled, and there is no way to make them do it. The only possible solution that I can see is the use of internes, and how far that is feasible I am still a little at sea. That is the only suggestion that I have been able to get out of handling myself three or four different dispensaries, that if we can get sufficient internes, we can do it that way, and if we cannot, we are not very liable to get it done.

DR. TANNENBAUM: It can be done very easily and has been done at the Jewish Hospital, Philadelphia, with which I am connected. Upon admission to the dispensary every patient is referred to the Medical Department for a com-

plete physical examination, this reference to the Medical Department being made irrespective of the fact that the patient may come for treatment in some other department of the dispensary. The result of this examination is recorded upon a specially prepared form which has headings and leading questions, this form being put into a folder with any other reports pertaining to the patient, and is sent to the department to which the patient is finally referred by the Medical Examiner. The advantage of a complete physical examination of every patient is very obvious, because the patient is not always able to decide what department he should go to, he may ask to be referred to the Eye Clinic and upon examination it may be found that his eye trouble is due to Diabetes or some other complication.

I admit that our dispensary is not a very large one treating between 1,500 to 2,000 patients a month, but there is no reason whatsoever why this plan of physical examinations for each dispensary patient cannot be put into operation in any dispensary, the matter simply depending upon sufficient accommodations as well as a sufficiently large staff. Since putting this plan into operation we have found it working most satisfactorily, our attendance having almost doubled since its adoption.

CHAIRMAN RANSOM: Has any one had experience of that kind in a larger out-patient institution than Dr. Tannenbaum's? Two or three dispensaries that I know of with an in-take of fifty to seventy-five new patients per day would keep an examining department pretty busy, and if that examination was done in the medical department, it would probably call for a certain amount of differentiation of function in that department, because there would be a certain number of those patients that ought to start in that particular department and have treatment there possibly for some time. It seems to me the thing is practicable with reference to certain types of patients, and is not so readily practicable as to others. I know a good many patients that have come to the two dispensaries with which I have been connected, who, while we may be missing an important thing that is the matter with them, come in to see the eye doctor and would leave if it was suggested that they have a complete physical examination. I admit that allowing the patient to make his own diagnosis, even of what may be the general location of his trouble, is not good, but it does seem to me that there are some decided problems present-

ed there. The patient may be discovered in your physical examination to have only the need of a specialist. Is your examination as complete in the case of the patient who needs a refraction, let us say, as it is in the case of a patient who has a gastro intestinal disorder?

DR. TANNENBAUM: A complete physical examination as to heart, lungs, etc., is made of every patient, gastro intestinal examinations being made, when indicated.

CHAIRMAN RANSOM: How much time is given?

DR. TANNENBAUM: New patients are given 20 minutes, two hours being devoted to this work in the morning, four examiners working in two shifts, two from 10 to 11 o'clock and two from 11 to 12 o'clock.

Those who come to the Medical Clinic stay there of course, the others being referred to the department to which they ought to go, which may not be the department for which they ask, the Medical Examiner deciding upon that, after having made a complete physical examination of the patient.

CHAIRMAN RANSOM: Is there any one here who has had experience in having this complete physical examination made in the special clinic to which the patient may more or less assign himself, like a complete physical examination in the genito urinary department? Mr. Davis, the subject we are discussing is how to procure complete physical examinations for a larger percentage or for all the patients coming into the out-patient department; can you say something for us on that subject?

MR. MICHAEL M. DAVIS: I was thinking of a skin or syphilis clinic where it was the desire of the chief to see that every patient with syphilis had a general examination. The difficulty was that it added considerably to the time, required more staff, more space, and then it became apparent that to comply with it meant that there should be an oculist; in other words, it meant building up within the syphilis clinic a complete diagnostic clinic itself, and that was too big a job. As a result, this compromise was adopted; a brief examination of the chest and abdomen was made by a physician, who would also go on and treat the case as a syphilis patient. That obviously added to the time required for the new patient, but it was thought worth while. It probably added ten minutes to the time taken with the new patient. The history was taken, anyway, the patient was brought in and undressed anyway, it added at least ten minutes to the time. It has been felt by the staff of that clinic to

be extremely beneficial although rather a burden, because of the fact that it was impossible to increase the space or increase the staff sufficiently in the space available to make the burden of the work as light as it should be. That occurs to me as one illustration of the point that I think has to be considered.

CHAIRMAN RANSOM: Some out-patient departments have tried to solve the problem of the proper distribution of patients to the clinics to which they belong, by having a medical man at the admission desk. I wonder if there has been any effort anywhere to go a little further and have a cursory examination made by a medical man before the assignment of the patient by the clinic? Not a complete physical examination but have the assignment of the patient based somewhat on what would be evident to the medical man making a cursory and brief examination.

DR. HENRY, of St. Louis: The making of a complete physical examination of all clinic patients in the general dispensary service of the City of St. Louis was not continuously or consistently done. We did occasionally for purpose of study make physical examinations of all those patients being treated in some of the special clinics, to determine how many of them had other conditions for which they required treatment. The results are sometimes rather astonishing because many important conditions in patients who have not received a thorough physical examination will be discovered. We found sometimes cases of tuberculosis coming into the dispensary other than the chest clinic and segregated them out. This was not recently, but some 10 years ago, however I think any of the large clinics that are not careful to make at least a cursory examination are liable to be treating patients in special clinics without discovering many very important conditions which should be discovered for the benefit of the patients and of the community.

CHAIRMAN RANSOM: Has anyone else anything to offer on this subject? I would much prefer to have some questions coming from the floor.

DR. DAVIDSON: Mr. Davis was saying this morning that there was some difficulty in securing physicians to take care of clinics and I wanted to ask, first, do these physicians in attendance at the clinics have hospital connection and if not, why not? I remember in Dr. Emerson's survey of the Cleveland situation, he stated that a

very small percentage, I forget just what it was now, of the physicians in Cleveland had hospital connections.

MR. MICHAEL DAVIS: The question is whether the physicians, in the clinics in New York City, I suppose he meant, had hospital connections? There are two kinds of dispensaries, independent dispensaries and dispensaries which are out-patient departments of hospitals. Those physicians working in the out-patient departments have, some of them hospital connections, but the larger number of the men working in the out-patient departments have no hospital connections, except the chief of clinic, who, as a rule, is a man who holds a position on the hospital staff with some bed privileges. The men under him, who may number one or a dozen, often have no hospital privileges; they may be authorized to go about and make general rounds once a week, but that is an honor without very much privilege attached. I think there is no doubt that the men who have hospital connections prize the hospital connections very much. I might mention an example of a nearly ideal organization, namely the pediatric department of Bellevue Hospital, where every man in the large pediatric clinic has a hospital connection; every clinic man must serve in the hospital and every man in the hospital must serve in the out-patient department in that particular division; there is no service in New York City more regular and thorough in both branches than that particular one.

CHAIRMAN RANSOM: It seems to me that this question relates itself to the larger question of how to secure good medical service in the out-patient department. Many men in the out-patient department who are not on the hospital staff are in the out-patient department because they hope to get on the hospital staff, except a few who had that hope and now haven't it but still stay in the out-patient department. I might say one word about a thing we are doing in the Michael Reese Hospital, that we hope will have some value in that particular. The Board of Trustees of the hospital recently passed a resolution to the effect that when vacancies occur in the associate or adjunct ranks of the staff of the hospital, first consideration will be given to men who are giving satisfactory service in the out-patient department; that a man might go to work in the out-patient department with the expectation, or with more than that, with a certain amount of assurance that good work in the dispensary will be given serious consideration by the staff

or by the trustees when there were openings on the hospital staff proper. In fact, since that resolution went into effect, there have been some promotions from the dispensary or out-patient staff to the staff of the hospital. It seems to me that the local condition, the condition of the particular institution, is going to determine whether all of the members of the staff of an out-patient department can have actual work in the hospital. It depends a good deal on what has been, on the size of the hospital and the essential size of the staff of the dispensary. In some departments, in some hospitals, without going into the out-patient department at all, they have more staff members than can readily be used by the hospital itself. I think that we are getting away, however, from the idea that a man may be good enough to work in the dispensary but not good enough to work in the hospital. Is there any other discussion of this question?

DR. FRANK BILLINGS: May I say a word in that connection? I think that what Mr. Davis said this morning is one of the essential principles in the solution of this problem as well as others, and that is that the hospital and the dispensary should be considered one field of endeavor in welfare work. Unless that is done there is bound to be a lack of coordination in the work of what is always considered, or in many institutions considered, as two institutions. As hospitals and dispensaries have grown, they have not, in many instances, been under the same boards. In some instances the hospital is under one board of management and the dispensary under another, and in all matters of administration and all matters of financing the institutions, and in all matters of organization of staffs, social service and all that, the two institutions are sometimes quite apart. Now, in relation to the staff, the medical staff of the two; the desire to be in the hospital, not in the dispensary, is due to the lack of information upon the value of service by many medical men. It is due also to the fact that the facilities for work in most dispensaries are inadequate for the purposes of the institution. I believe that every dispensary should be a diagnostic clinic. I think the name diagnostic dispensary would be better than just to say dispensary, because the chief purpose of a dispensary is to care for patients and to know whether they need hospital care. Every hospital worthy of the name and sufficient in size having a community to serve, ought to have



an out-patient department, ought to have a diagnostic clinic through which the majority of the patients go to the hospital. I will make this as a comparative statement only, but based upon experience I would say that of all the ambulatory patients who come to a well organized dispensary in the community, approximately twenty per cent need to go in hospitals; eighty per cent can get on with ambulatory care. Therefore, if we could organize the hospital with its out-patient department as one organization, with its one staff, with its one administrative board, with the facilities for diagnosis common to the whole institution so that the out-patient department of the hospital could utilize all the facilities of diagnosis belonging to the hospital, we would have less difficulty in securing a proper personnel in the medical staff. I practiced medicine a little over forty years. The first seventeen years of that service was entirely dispensary but with a hospital service in Chicago, one of the rather large hospitals. The dispensary was unconnected with the hospital in which my service lay, but they were in the same community. My service in that dispensary was a far greater satisfaction to me, of greater value to me, than a large medical service in the hospital. Why? Because I found a rarer, better material for examination in the out-patient department than I did in the hospital. Therefore, I spent more time, by far, in the dispensary, for teaching, and found it of greater value, of greater attractiveness to the medical class, than the patients in the hospital, because I could show them more. Furthermore, that medical man who awakens to the opportunity, finds in an out-patient department more frequently the beginnings of disease, manifestations of the beginnings of disease, than anywhere else. When the patient reaches the hospital, he finds the end results; and, therefore, the dispensary is a much better place to teach the man who is going to become a practitioner and go out into the community to practice. In England, Scotland and Wales, in Germany, more particularly however in Great Britain and Ireland, in the out-patient departments of hospitals, the personnel, is quite as strong in character and qualifications as in the hospital itself. If there is any difference probably the better men are in the dispensary. It is true that they work through the dispensary and in the hospital, too, before they become consultants in Great Britain and Ireland, a different aspect from our own, but nevertheless if we would give facilities in our dis-

pensaries, if we could have an organization common to the hospital and the dispensary itself, and give young men an opportunity in both the dispensary and the hospital, there would be no great difficulty. Now there is one other point I want to make after what Mr. Davis said this morning, and that is the financial side. Of course if the two institutions were one, under one organization, under one administration or administrative board, any means for raising money for the one would apply of course to the other and there would be far less difficulty in financing the out-patient department than now exists in many institutions, but here is a peculiar paradox, there is a peculiar psychology of the medical profession and of the public; the hospital doors are open, if they have private rooms or wards where pay patients may be received; I don't know in Chicago, and I am pretty well acquainted with Chicago, of a hospital that would close its doors to a patient who was able to pay ward fees or room fees, but the moment the dispensary with which the hospital is connected, either directly or by affiliation, receives a patient who has sufficient money to pay a small fee, then somebody complains. What is the difference? I cannot see, and yet of course to protect the public, and I include in that public the medical profession, from pauperizing people, we ought not to receive indigent patients, those in the dispensary who are able to pay a doctor. But we can amplify, if we give opportunity for diagnosis in the dispensary with a personnel able to do it, with facilities of all kinds to do it, then we can open the doors to diagnosis to any one sent by doctors, only sent by doctors, though. That is, if a physician in the neighborhood desires to have a diagnosis made upon a patient able to pay five dollars or three dollars or ten dollars for the solution of a problem that requires time, then I would say open the doors of that dispensary to the patient with ten dollars which is a fee for the dispensary, but only to those patients able to pay who are sent by the physicians of the community; and let me say that if the dispensary would adopt a policy of cooperation with the community, with the doctors of the community, treating them fairly and sending the patients back after the diagnosis is made, much of the so-called charity abuse on the part of the doctors would disappear and yet the dispensary would receive a larger income than it now receives. Finally, to sum it up, we never will have this matter right until the dispensary

and the hospital are one institution, and the dispensary, ought to have the opportunity to use all the facilities of the hospital in making a diagnosis of the ambulatory patients, and if the hospital would amplify its service to the community a hundred fold, it will utilize the dispensary for diagnostic patients and take only those patients into the hospital as a rule who go through the dispensary. (Applause)

CHAIRMAN RANSOM: Dr. Billings not only answers some questions but raises some. One question which he asks was also asked by one other person. It was how may the dispensary serve the physicians of the community who are not on its staff, and how may it secure the relationship with the doctors in the community that will make them make use of the dispensary? I would like to ask Dr. Billings a question, however, before that question is discussed. In this diagnostic service which the dispensary would perform for the patients of physicians who might send in those patients for which a fee would be charged, would you or would you not compensate the doctors in the dispensary doing that work?

DR. BILLINGS: Yes, I would compensate them, but would not let them personally collect the fee; I would establish upon that policy and principle a service or part pay service of the staff, but I would not have a doctor collect the fee from a single individual patient.

DR. TANNENBAUM: How would the fee to be paid by the patient in such a clinic be determined?

DR. BILLINGS: It should not be less than those paid in that community by patients able to pay. No institution should become a competitor of the doctor by making diagnosis for him for less than somebody else outside would do it.

DR. TANNENBAUM: Dr. Billings has mentioned a fee of three dollars; no physician who has any consulting practice would make a diagnosis for three dollars; it is ten dollars to twenty-five dollars.

DR. BILLINGS: That is an office fee.

DR. TANNENBAUM: But this would be a consultation.

DR. BILLINGS: What are you going to do with that middle class of people who are not poor in one sense? They are self-sustained and yet they cannot stand a long siege of illness and cannot pay big fees. They cannot even pay ten dollars diagnosis fees; they cannot pay for trained nurses, and yet they want to pay their way. Doctors take care of them now, and you know how they

take care of them in many instances; I see it everywhere; I did when I was in active practice; they come and they are not examined, that is they have no adequate examination, and they charge them fifty cents or a dollar for what they do. If they would give them an adequate examination the patient would give them five dollars and it would be within their means to do it. Now why should not the dispensary, if that doctor has not all the facilities for doing that work, do it for five dollars and turn the patient back with a communication from that dispensary indicating the exact condition of that patient and what should be done in the management of the case?

DR. TANNENBAUM: I agree absolutely with Dr. Billings that such a clinic is most desirable; as a matter of fact, I have had the honor to be connected with a committee in New York City at which such a diagnostic clinic was discussed and was ready to be put in operation when it was found that there were some legal obstacles to it and it could not be put into operation. It was sponsored by the Academy of Medicine, wasn't it, Dr. Davis?

MR. MICHAEL DAVIS: Yes, it was approved by the Academy.

CHAIRMAN RANSOM: I believe that as soon as you go beyond charging enough money to make the service self-sustaining, the rest of the money should go to the people who do the work. Of course, there you have a tremendous job to educate the medical men of the community. I think the chief reason why this is not being done on a larger scale is the fear of the opposition of the doctors who will oppose it because in part they are doing work on just about that same financial scale, not doing it as well, naturally, as a medical institution can do it, and the question many of us will have to solve eventually is whether or not the medical institution shall, in a measure, enter into a certain amount of competition with the physician who has much lesser facilities and consequently cannot give as good service as a medical institution can. Of course in a measure this question is being met by the pay clinic with the paid physicians, and there is and can be much less opposition on the part of the doctors on the outside to pay clinic in which the physician is paid for his services. Of course there is again the argument that the institution has a great advantage over the physician in the way of publicity; it does not exactly advertise, but its existence as an institution is something of an advertisement that the private practitioner does

not have. It seems to me that as Dr. Billings says it we can give a larger measure of service to the physicians of the community from the dispensary in relation to the things they need, there will be less opposition on their part to our wanting to render better service to out-patients whom they cannot adequately serve.

DR. A. N. THOMSON: On what basis are you going to compensate the physician? After a good deal of discussion in a great many of the venereal disease clinics throughout the country—the principle some of us tried to work out is that the physician making \$10,000 a year net after he has paid all his expenses working the number of hours in an ordinary day's labor, is getting about \$5.00 an hour. The clinic that is paying the physician on that basis is paying him \$10,000 a year, of course, but paying him on an hourly basis. The patient who pays anything over the average fee charged by the physician is in the wrong place from the point of view of a good many of the men who are working in venereal disease and work either in or out of the dispensary, but if you can adjust your dispensary charge so that the patient is not paying any more than he would have to pay for adequate service outside, a minimum fee outside, and the physician is getting not less than a \$10,000 a year income on an hourly basis, the combination is somewhere in those two factors. I have not been able to work it out and I do not think anybody else has, but it is a basis, to begin to think from on the financial charge proposition when you come to the question of paying the physician. I would like to hear somebody say how we are going to figure out the compensation of the physician who is working either in the pay or the free dispensary. The doctor ought to be compensated on an adequate basis and thus avoid a good deal of criticism in the profession at large.

CHAIRMAN RANSOM: Will someone answer that question of the compensation in the dispensary, either in the pay clinics or in the free clinics? It is very refreshing to some of us to know of a few physicians who are paid for working in the free clinics of a dispensary; it gives us an assurance of service that is most gratifying to the administration of the institution.

DR. BILLINGS: I do not think anybody can answer that question. Our tradition in the medical profession is that in both medical schools and hospital dispensaries, especially in dispensaries, that the service rendered without

pay was compensated for in other ways; that is, that the knowledge gained in teaching, the knowledge gained in practice in the dispensary was sufficient pay for the man who was willing to take it up. With changed conditions the problem has become more acute, and the question as propounded tonight is one that, presented under present conditions, is unanswerable. There are few if any dispensaries that have a sufficient financial budget to give pay, part or whole, for attendance. There are some that can pay for a part time service, that is an hour a day or two or three hours, or perhaps for one man in each service, and the remainder serving without money compensation. That is unsatisfactory. In hospitals where there is a private service, pay service, compensation is secured for hospital attendants by the pay patients which members of the staff may have; but in public institutions in the west—I do not know how it is now in New York, Philadelphia or Baltimore, but in our great institutions in Chicago, our county hospital which is really our municipal hospital, and our infirmary out in the country are maintained by unsalaried men. The medical men on the staff of the county hospital are also under civil service; they take their civil service examination, and that examination must be repeated every six years if they hold that service, and they are obliged to give a certain minimum attendance to the wards which are assigned to them. Some of them teach and some do not. There is always competition when those places are up for civil service examination, and they are popular places to hold. In the private or semi-private hospitals, most of them have private physicians for members of the staff, especially the chiefs of the departments, making in Chicago, as they do in other large cities, relatively large incomes from the patients they receive. But there is a selfishness on the part of the members of the medical profession that do not give the younger men, the men who have less reputation, an opportunity to make a part of a living, at least, in this way. The fault lies partly in the medical profession, partly in our own methods of organization due to the fact that medical education and the care of the poor was left entirely to the medical profession and we have not gone entirely away from it yet; therefore it is a problem before us that has got to be solved, and one of the ways of solving that will be for a hospital that is large enough in a community big enough to have a diagnostic clinic as its out-patient department, to receive in



that clinic anyone, and by so doing to finance its whole operations including salaries and doctors. Now the Mayo clinic is founded on just such principles and policies. If I am not tiring you, the beginning of it was with a cyclone which visited Rochester in 1883. There was no hospital in the town. There was a Catholic school, St. Mary's school—the elder doctor, the father of the two Mayos, was then practicing medicine there and the school was opened by the sisters as an emergency hospital, and it has remained as a hospital ever since and has grown under the practice of the two young Mayos with relatives, a brother-in-law and others added to the staff, and for years received but small fees. It has grown into an enormous diagnostic clinic that has relatively until recently, few hospital beds considering the size of the clinic. Last year I was told that their daily new patients were 300. Forty per cent of the patients that go are unable to pay fees. Now that would apply to any hospital in any big city if they had a diagnostic clinic open to all, about the same proportion of indigent patients would go to that clinic with pay patients who were able to sustain the whole clinic. If it can be done by the Mayos with full justice to the medical profession—and their justification of their organization and method of administration is that every patient who goes there is received and examined and treated thoroughly, money or no money, and that the doctor from whom the patient comes is notified when the patient comes, what the condition is, what is needed, and sent back to them with a letter. Now we can go further than that, because their patients come from all over this country and from foreign countries, but in Chicago, New York and many other big cities, the patients would mostly come from that environment and it would be easy to get in touch by telephone or by other means with every doctor from whom a patient would come, and it would not be long until the service of the institution, including the diagnostic clinic, to the community including the doctors in the community, would be such that it would be as popular as the Mayo clinic is to the people. Now that is my belief.

CHAIRMAN RANSOM: Some of you, I am sure, have questions you have not propounded.

DR. BILLINGS: I would like to know what Mr. Davis thinks from his experience with dispensary work, of the proposition of an organization along that line.

MR. MICHAEL DAVIS: I think that a diagnostic clinic along that line is perfectly practical. I think it would be a tremendous step in the right direction, but I do not think it meets entirely the need; there is a good deal of treatment work, particularly eye work, nose and throat work, skin work, venereal disease work, etc., a good deal of treatment which a large number of the people cannot pay for at the rates specialists must charge in their private offices. Take eye work—the oculists generally charge not less than \$5.00 for an eye examination. A large number of people, unless they suffer very seriously, will not or cannot pay \$5.00 for an examination by an oculist, they will not pay \$5.00 to have their children sent to an oculist, and as a result they do not get the service for that kind of case except in an emergency. In such specialties there the problem is relatively simple because there is very little opposition generally upon the part of the specialists to the development of clinics taking patients for moderate fees, fees which the patient can pay, which are much below the specialist's charge. There is practically no competition between the oculist and the general practitioner because the general practitioner does not attempt to do eye work; so I think it is fairly easy to handle the non-competitive problem of the specialties. Your diagnostic clinic plan would meet the most difficult end of the problem, because it would apply to those who would go to the general practitioner but cannot get adequate diagnostic service from the practitioner without the equipment.

DR. THOMSON: The procedure of the Mayo clinic as it has grown and developed, is just about as Mr. Davis has outlined?

DR. BILLINGS: Yes.

DR. THOMSON: They develop their specialists even after they made the diagnosis on some primary condition, and then the secondary condition they carry right through, and they have got the eye department and nose and throat department, etc., with continued treatment after it goes back to the physician until they can get the patient in the position where the ordinary physician can carry on.

DR. BILLINGS: In other words, for a moderate fee, the dispensary diagnostic clinic can help out the poor patient and at the same time help out the doctor, and it helps the doctor because the doctor carries on the treatment for the small fee which the patient can afterwards pay him, but it is of inestimable benefit to the whole community inasmuch as the machinery is there with which

the work can be done. It is helpful to the hospital because it is fairer to the patient that goes into the hospital; it helps finance the institution and places them where they finally can pay these young men salaries. It multiplies the benefits of the hospital to the community and makes it more easy to successfully conduct a campaign to raise money by subscription for the hospital and the dispensary. In every way it opens the doors.

CHAIRMAN RANSOM: Are there any further questions you wish to present? If not, I want to say one thing, and that is that I think I am voicing the sentiments of all those who are here as well as my own when I say that this round table has been a great satisfaction and it has been gratifying and valuable to have a man of Dr. Billings' experience and wisdom enter into our deliberations, and I want to thank him.

The meeting then adjourned.

## SECTION ON NURSING

September 15, 1921, 2 P. M.

Miss Mary M. Riddle in the Chair

CHAIRMAN RIDDLE: Our purpose in coming here this afternoon is to discuss old problems. You will hear nothing very new. They are problems which are causing us labor and, to some extent, anxiety. We may not reach a satisfactory conclusion in any case, but we shall be better for having come together and for this opportunity for presenting our views. We shall be the better, also for hearing from those who do not quite agree with us and for getting their point of view, which will be helpful. You will find, I trust, that all our efforts are in the interests of better care for the sick. Whatever form they may take, or whatever our discussion may be, that is our ultimate object. We expect no long papers, in some cases they are intended only to present the question and draw out discussion. The first one of the afternoon is on a subject which has been interesting the schools of nursing throughout the country, namely, The Shortage of Nurses in our Schools, Causes and Remedies, and we hope to hear of a possible remedy. *This paper*, written by Miss Nancy E. Cadmus, recent superintendent of the Manhattan Maternity Hospital of New York City, is

short and touches only upon the salient points and will be read by *Miss Mary E. Subray* of Peoria, Illinois.

MISS MARY E. SURBRAY: In attempting to discuss the question of the shortage in candidates for the schools of nursing it is rather difficult to find a form of presentation that is not more or less a repetition of what has been said many times over in print and on platform, with a general recognition of how little, so far, has really been accomplished in either explaining causes, or discovering remedies.

None will dispute that it is requiring considerable effort to hold fast to our optimism, but when the reversal comes, as it surely will, we shall be glad that we did not yield to the discouragements and become pessimistic.

Today normal schools for teachers, seminaries for theologians, in fact, every educational institution, save perhaps colleges and universities, are suffering from shortages in their student ranks. This, coupled with the very generally recognized disinclination to assume responsibility, may very properly be used to in part explain "causes."

At the present time young women completing high school find the path to college comparatively easy, while others not completing a high school course, either from financial reasons or disinclination, can readily find openings of various sorts where they may prepare themselves with a minimum of effort, time and expense, for future earning power, or begin at once in clerical or industrial positions which provide a freedom and contact that appeals to them.

The following is a picture from real life which has fallen under the writer's own observation. A first-year high school girl takes a position in a Ten Cent Store in a city eight miles distant from her home, which is in a pretty little village located on a lake where boating, bathing and fishing in summer, with all ice and snow sports in winter, can be indulged in. This young woman is transported morning and evening to and fro in a seven-passenger automobile owned by the family, with the long evenings for such use of it as she may care to make. This incident is cited because the idea is undoubtedly very true in many, many instances with differences in settings.

Not in a spirit of cynicism, nor with any idea that we should accept conditions in a pessimistic manner, do we acknowledge that the living along the "line of least resistance" is very universal today, and the "spirit of serv-

ice" is all too often wanting, but when adults are possessed with the spirit of discontent and restlessness, can the youths be expected to out-distance their elders in manifesting the qualities that constitute the essentials of stable, self-sacrificing character? The present is truly youth's day. Of those who entered the service in the late war the great majority were very young, therefore is it any wonder, when thousands of them were thrown out into such bold relief, that there should follow a reaction, when they, of both sexes, should resist all that is serious, or partake of the nature of responsibility? Not that such is to be excused or condoned, but certainly it is one of the problems of the day, and do what we will we cannot close our eyes to facts.

In seeking the causes for the shortage among nurses I frankly admit that I disbelieve in the question, in the general sense, being attributable so much to specific reasons as to those that affect life in general. To put the matter concisely, the shortage in recruits for our schools of nursing is no more wholly due to peculiar conditions inherent in the whole scheme than is the case in other educational fields—the causes for this as well as of the others may largely be traced to psychological disturbances which have unseated the promptings of our better natures, but temporarily we trust, and placed there a spirit of rebellion against concentrated effort which in plain terms spells *work*.

It may sound harsh, but too great material prosperity has turned the heads of many and only the heavy hand of necessity will lead us to comprehend how unsatisfying life is without self-involvement in all its plans and schemes, and that no real success can be secured without the acceptance of responsibility in the world's affairs and needs. When this becomes true this particular activity will again emerge into the field of eagerly sought opportunity, in different form undoubtedly, but we may hope the same in fundamentals. However, so long as the tendency to commercialize rather than to vitalize, to materialize rather than to spiritualize our gifts for serving in our own niche in the world prevails, little hope can be placed upon real results.

In turning to discuss "remedies" for this shortage, we find the search for "causes" has been child's play in comparison, and, frankly, I can only say that it is, to my mind, entirely a matter of time—time for readjustments to develop; and this period of unrest, the reaching

out for we know not what, and the general bewilderment of the human mind as the outcome of the disturbed psychology of the world, to have had their day, when we, once more, will have a liking for service and work that affords expression of our best selves.

CHAIRMAN RIDDLE: Before opening discussion on this subject, we would like to hear what has been accomplished by one of the so-called smaller hospitals of the country, and I would therefore ask Mr. Davidson, superintendent of the Hospital in Rockford, Ill., to tell us of the measures taken for reducing their shortage.

MR. SIDNEY G. DAVIDSON: Ladies and gentlemen I have no excuse for being here at all except just the kindness of our Chairman. It is not because I am under the superintendent of nurses that I am here, it is because we are working together. This hospital business is exactly the same as every other business in this country, it is a selling game through and through. You are selling a service; you are selling the education of your training school, and when you are selling anything you have to manufacture the very best thing that can be manufactured and then you have to put it on the market, you have to advertise it and you have to have your salesmen; it is the only way that a successful business is carried on, and it is the only way in which returns are brought to the successful business man; and surely there is nothing more worth while selling in this world than the education of the young woman to care for the sick. I hold that the time when a person is sick is the time when they need the very best, and you are not going to give them the very best unless you are giving your pupil nurse the very best training, and you are not going to give to them the very best unless your hospital is back of that and doing everything in its power to make the service in that hospital the very best; and if you are doing that, well, you have to advertise it, you have to get your salesmen out, and then after while, just like every other commodity that is manufactured and advertised and is worth while, it begins to sell itself. I have had that idea in my mind for many years, and this year I have had the opportunity of putting it into practical application. Last year there were three young women came into the Rockford Hospital Training School. In February the Board of Trustees spent nearly \$900 in advertising in all the small papers in the communities round about, and up to the present time they have not had any replies.



And so we started in to sell our article. We said "We have as good a hospital as any in the country; surely we have as good a training school as any in the country." We got out our literature, and among our graduates was a young woman with a college education who, for the past five years, has been at the head of the school nursing in Rockford. I called her to my office and I said "I want to employ you for the summer as a salesman. Now here is all the literature; we are going to give you prospects and we will give you transportation, and I want you to go out and sell this hospital, I want you to go out and sell this training school and sell this whole great big idea of nursing." The doctors became interested in it and they secured names from every doctor out in all the outlying communities, and they flooded that girl with the names of prospects. The Red Cross gave us the use of their automobile. The Chairmen of the local Red Cross in the various communities gave names, and so when school finished, this young lady started out. She did some work in Rockford and then she started out to the outlying sections. She went to the chairmen of the local Red Cross, to the ministers in the communities; she got names and then went to see not only the young prospect, but the father and the mother of that prospect, and she talked hospital, she talked nursing and she talked Rockford Hospital Training School in that family.

She worked six weeks; she interviewed 211 girls, and in every instance saw either the father or the mother and in most instances both members of the family. Of the girls she saw, 56 were not employed and had no definite plans for the future; 116 expressed no inclination for or interest in nursing; 75 were interested; 46 were ineligible, either being too young or having insufficient education; 10 were unable to enter the training school because of lack of funds. Fully 50 per cent of the girls interviewed objected to the three year training, believing that the hours on duty were too long and that the nurse was too isolated from the normal life as compared with girls who are employed or in college. The attitude of the parents, relatives and friends generally was apt to be antagonistic to nursing and most discouraging to a young girl with an inclination to go into the profession. It was rare indeed to find both father and mother agreeing to their daughter becoming a nurse, especially if she were young, that is, between the ages of 18 and 22. The apparent objections were that the work was too hard and

that the three years was too long. These objections regarding the hours and the years of service were held mostly by the mothers, and especially by the mothers on the farms. Now I would like to have you get the location here. Rockford is a community of 75,000 just 100 miles west of Chicago, a business section doing business with all the outlying communities, a wealthy farming section, and very many of these girls are going into college. I think that the number was nearly 65 per cent of the young girls throughout that section who are going to colleges.

The fathers, on the other hand, objected to their daughters going into nursing because of the moral hazard. I think this is a matter of some interest, that the father should feel that way. I have found that same objection in the south, held strongly all through Arkansas, Missouri, Mississippi and Tennessee. I found the same thing true in Ohio, and here I come up to this section and I find it just as true. In regard to the hard work, it was very easy to overcome that objection. The three years' course, in talking to the mothers, was not so easy to overcome, and in Rockford we are giving serious consideration to the idea of inaugurating in our high school a pre-nursing course. In fact, our Superintendent of Schools is going to start it in a very small and limited way this year and let it grow for a year, and next year I am sure we are going to have something worth while. A pre-nursing course, where a girl can obtain credit sufficient to give her credit for one year of work in the hospital. I do not know whether it is going to work out or not; it is something we are going to try. The net result in pupil nurses was that we had 9 probationers coming in on the first of August and 7 more on the first of September, with 14 signed for next Spring.

How much good this propaganda has done, no one of us can tell; it cannot be measured, but I believe that it has been considerable both in educating people as to the benefits of the hospital and as to the greatness of the nursing profession. We ourselves perhaps have received the greatest amount of benefit, particularly from the complaints and from the ideas advanced by the fathers and mothers, and I assure you we are being guided accordingly. We have learned that we must start an education of the father and the mother regarding nursing, regarding the schools of nursing, regarding the whole profession, and we are having printed literature which deals with the

whole question of hospitalization. We are dealing at great all important matter. They have their county picnics length in this literature with the school of nursing and with the profession. It is our plan to send this literature into every home within a radius of 30 miles of Rockford. Our farmers' grange furnishes us with the name of every farmer, so that we can very readily do this. We are attending and have attended gatherings of farmers and are taking the opportunity of addressing them on this all important matter. They have their country picnics or county fairs and we are attending every one of them and having our opportunity to talk about this work. We are building up a force of salespeople, if you can so term them, and in the next three of four months we are going over this same ground again with additional literature, with four or five nurses, graduated from our hospital, taking this same story back into the homes again. That can be done in a period of two weeks, or three at the outside. This whole effort cost us the sum of \$267 this summer. The literature that we are now having prepared will cost us, for mailing and printing, about \$200, and I am sure that the results that we will obtain will be worth the expenditure of many more hundreds of dollars along this line.

CHAIRMAN RIDDLE: I am sure you will be glad to know how the shortage was overcome in one of the New England states. We have with us this afternoon Dr. Bresnahan, Superintendent of the hospital in Bridgeport, Conn., who will tell us something about their efforts, as well as other items of interest.

DR. JOHN F. BRESNAHAN: We had a shortage of nurses in our hospital of 275 beds last year; there were 13 probationers; as our present pupils began to graduate, the shortage became very acute, and hiring graduate nurses at \$5.00 a day threatened to swamp our finances. We indulged in much academic discussion as to the cause of the shortage, but with no results, and finally came to the conclusion that we would have to set aside theory and attack the problem from a practical standpoint. The first thing to do seemed to be to get a broad-mined, well trained, experienced woman who could put our training school where we could advertise it honestly. We did that, and what I have to say this afternoon—the credit is mainly due to our superintendent of nurses, and it gives me pleasure to pay a tribute to Miss Katherine Kimmick, whom a great many of you know. She came and reor-

ganized our training school. The first thing we did was to reduce, for the coming year, the training from three years to two years and four months, but we doubled the curriculum. We did that by taking up lost motion and trying to make an honest to goodness training school instead of a place where the nurses received most of their training in a practical way. With our incoming class of probationers, we do not expect them in the wards for more than an hour, or at most two hours a day, until January. The next thing we did was to utilize the idea Mr. Davidson emphasized, of selling the hospital to the parents. We called in an advertising agency in New York, had the man come over and drew up an advertisement, not a small one but a big one, taking up a quarter of a page, and we ran that in all the prominent Connecticut papers for two issues, on Wednesday night and Friday night. That cost us \$487. Within three weeks we had 136 applications. We then knew it was necessary to follow through on these applications or when the time came pupils would not come in. We then had a moving picture made of the nurses' life in our hospital, and it is an honest picture. It took four days to take it and cost \$1,300—it is in two reels. The next thing we did was to utilize that picture, we gave it publicity in the papers and had the first showing at the Country Club before the local Society. They approved of it and we took it down to the Poli Circuit. They said "No, we are not interested in propaganda, we have a lot of it." We said "Don't say that until you see the picture; it was written by a professional and the leading part in it is taken by a professional." He saw the picture and was so much interested that he put us in touch with a moving picture man in Connecticut who is now syndicating that picture. We have ordered an attachment to a Ford automobile which will produce light for pictures and we intend to send that picture through New England and show it against the barndoor with a sheet on it, and in that Ford will be one or two volunteers from Bridgeport who sold Liberty Bonds and they are going to sell hospital nursing to rural Connecticut.

The Bridgeport Hospital realized that it was not doing its duty unless it made some arrangement to have the money invested in this picture utilized in other parts of the country, and arrangements were made with the Lewys Bros. Studio of Baltimore that they keep the negative and if any hospital wants the film, they can get it practically at cost of making, which is small. The picture

was taken in two reels, so that if desired the headings could be cut out, making one reel. On the day I left there were 35 probationers entered the hospital, which is our limit of capacity, due mostly to the reduction of our course and of the doubling of the curriculum so that they get a better training. It does not interfere with the law. Second, on account of the newspaper advertising, and thirdly the follow-up. Some of the applicants were unable to take the examination, which induced the teacher of the night school to give an intensive course to enable a great many of these girls who left high school at the end of the first year, to take advantage of the opportunity. They take these young women and give them an intensive course so that they may certify, at the end of the year, that they have completed enough of high school studies to credit them with at least two years of high school. It worked in our case and I think with a little forethought and the same amount of push back of it, it ought to work in any place. The object of showing this film this afternoon is to show how a moving picture can be made advertising and still keep your interest. Thank you.

CHAIRMAN RIDDLE: You have before you the opportunity of seeing this picture if you are in the moving picture theatre in the auditorium before 4.15. It will depend upon how we expedite our business and get through with our work as to whether we shall be able to see it or not. Is Miss Roberts in the hall? I would like to have her discuss this question. Miss Mary M. Roberts is the Associate Editor of the American Journal of Nursing. Miss Roberts.

MISS MARY M. ROBERTS, CO-ED AM. JOURNAL OF NURSING, Rochester, N. Y.: Had I known before coming to this meeting that Miss Riddle would ask me for this kind of a discussion, I might have had figures, because I believe they would prove very encouraging as to the enrollment of the students for the Fall classes. Anyone I have asked has either said "We have all we can take," or "We have not as many as we would like but have more than we have been having, and the ones coming are distinctly higher grade than we have been getting." I believe the message therefore is distinctly encouraging, due undoubtedly to the very wisely directed publicity of such people as the previous speakers to improvement in the schools, and due also somewhat to the changing economic situation. I cannot evaluate the various factors. I think the next problem is how to keep the students after we

get them, how we are to meet what Miss Cadmus in her paper described as a lack of the spirit of service. I think that depends on how we interpret that expression, the spirit of service. If we interpret it as the sisterhoods interpret it, as a subordination of individuality, a willingness to limit one's efforts largely to the walls of an institution, I think we can say that that spirit is not dominant in many of our young women, because we have taught them in their homes, in our public schools, in our private schools and in our colleges to be individualists. The generation that reared this generation we are considering tried to give them more than they had had themselves. It is perhaps an open question as to whether they have overshot the mark a little bit. At any rate, the young woman of today is an individualist looking for an opportunity for self-expression. It is bound to come out. It may come out in terms of frivolity, it may come out in terms of mere externals such as dress, it can come out, I am convinced, in a true spirit of service, but we will have to help them a very great deal more than we are doing in our schools.

By that I mean that I believe we shall have to evaluate a day on duty, or a week, or a month, not in terms of so many classes attended, so many baths, so many treatments, so much medication or so many nourishments prepared and taken to the patients, but in terms that are much more human than that. We shall have to help these very young women with their very limited experience of life, to believe and to know and understand that they are doing something that reaches far beyond the bed the patient is in; that the care of that day means something to someone who is exceedingly important to other people outside the walls of the hospital. How often do we stop to help our students visualize the homes from which those patients come? How much social service have we yet really done for our student nurses?

I believe we will get the spirit of service when the student realizes that what she has done for the patient means that the mother gets home to her children a little sooner or that the man gets back to his wage-earning a little sooner or that she has relieved a very definite amount of human suffering. We have kept away from that phase quite a good deal. This is not Victorian sentimentalism! We have got to evaluate those factors much more carefully than we have recently done if we are to hold the superior young women who are coming in, because only



in that way can they believe that their services have a value beyond the hospital; only in that way can they believe that their work really counts, that they are having an opportunity for the self-expression that they have so much craved and are now not always wisely expressing.

CHAIRMAN RIDDLE: Is there any further discussion upon this subject? Any questions to be asked? If not, we will pass on to the next subject, The Eight-Hour Day for Student Nurses, Its Advantages and Disadvantages, and Some of the Arrangements Required for its Establishment. This is an old question, but from recent questions received it would seem that not all have yet solved it. This paper has been prepared by Miss M. Helena McMillan, Superintendent of the School of Nursing of the Presbyterian Hospital in Chicago, and will be read by Miss Francis of the Children's Hospital of Philadelphia. I have great pleasure in presenting Miss Francis.

MISS FRANCIS: In speaking on the subject of an eight hour day, I can do so only as a strong adherent of its use for student nurses in all hospitals.

The reasons for its introduction are many. First, and possibly most important, is the effect on the patient of having a nurse care for him who is not over-worked and who for that reason can be bright and cheerful. This is not a theory, but can be borne out by the statement of innumerable patients as to their comfort and pleasure in having nurses come into their rooms with smiles, with no feeling of unkindness manifest towards their hospital to give not only conscientious but joyful service. The same effect that is felt by the patient is noticeable by all who come in contact with the student nurse so that her service to the Institution as a whole, is a better, more alert and a more interested one, than when she was held on duty longer hours.

The result has been so evident in at least one Hospital that the Board of the Institution has expressed itself as unwilling to consider a change to longer hours of service.

A second reason for a consistent and conscientious eight-hour system is mere humane-ness. There is a limit to the endurance of the young women who work in our hospitals as hard as all our nurses must do, and who in addition to the physical effort exerted are many times under heavy nervous strain worrying and anxious, exposed to all types of disease and who even when supposedly "off duty" are expected to study and carry class work.

If these student nurses work in the wards eight hours, under the exactions of the modern hospital, they do well, and in consideration for their general welfare, more should not be asked. Hospitals failing to recognize this fact, are open to the imputation of "sweating" and charges of other cheap labor abuses.

Undoubtedly hospitals have been guilty of much injustice in over-working the nurse and the immediate general adoption of an honest eight-hour service is one way to redeem the past.

The attitude of parents and prospective candidates for entrance into nursing schools is another quite strong argument in its favor and the presence of the system in a school does much to make both parent and daughter willing to accept other conditions which are not ideal and helps bring into the school the number needed for the nursing of the Hospital. During the past eighteen years, the writer knows of many instances where the choice of a school has been made solely on account of the existence of an eight-hour duty in the selected school.

The advantage to the young nurse is considerable, and the shorter day not only saves the student's strength but brings to her other things she values; an opportunity to benefit by class instruction given in the day time, instead of in the evening, when general weariness prevents either interest or profit; the rightful opportunity to continue her contact with at least a few outside interests, so that her mind may not become closed to normal affairs, allowing her to maintain a healthy point of view otherwise impossible in a life spent among abnormal conditions.

The happiness that comes to a student nurse through her ability, on account of a little extra free time, to make some independent plan to lunch with a friend, to do individual reading, anything which relieves the continual pressure and acknowledges her need for some individualism fully repays the institution by what she brings back in mental alertness, in interest and in physical freshness.

The effect on her health is noticeable and helps to graduate her in condition which will allow graduate nurse work instead of, as too often has happened in the past, sending out a physical wreck, who having made her contribution to society during her nurse training, must henceforth be cared for by her family or by charitably inclined people.

The objection has been made that the nurse wastes extra time given to her, that she uses up her energies unwisely, that she gets into mischief. The women now admitted to the nursing schools being frequently very young, do need guiding when off duty, as well as in their hospital work. With, however, a careful selection of candidates, a properly planned schedule of class instruction, supervision of study and rest periods, suitable recreation suggested and provided for, with a general oversight and interest in their pleasures, leaves little opportunity for great misuse of time.

But even should the young nurse occasionally make unwise use of her free time, however much it may be regretted, is no excuse for the hospital over-working her and would not be justifiable reason for rejecting the eight-hour service.

It has also been said that eight-hour duty for the nurse prevents the placing of responsibility upon the individual and is therefore detrimental to the nursing of the Hospital.

After an experience of twenty-four years with the system, the writer cannot recall an instance in which such a condition has arisen and has come to believe that if there is confusion and lack of proper results in the nursing of an institution, it is not due to the eight-hour day, but to its faulty administration.

Various divisions of hours are in use and each institution will have to adjust these to suit its particular conditions. After considerable experimentation, the following has been found a good working plan: All day nurses report on duty at seven o'clock and are given hours off duty between that time and seven in the evening, as the work of the Department will best allow.

In one department a nurse may be spared from nine o'clock in the morning until one o'clock, P. M., when having had three hours with an additional hour for lunch, she returns remaining on duty until seven in the evening, after which time she has her evening meal.

In a second department the earliest hour possible to release any nurse may be ten o'clock, this nurse returning at two and staying until seven o'clock. A second nurse may be given from eleven A. M. to three P. M. Another from twelve, noon, until four P. M.; a fourth from one P. M. until five o'clock; a fifth nurse may be released from the department for an hour at lunch time, return and stay on duty until four o'clock, when she has completed

a straight eight-hour day, while the last nurse is freed at one o'clock for her weekly half-day.

The aim of all departments of course, is to have the larger number of nurses on duty between seven and ten or eleven o'clock, A. M., a sufficient number on duty at meal times, a smaller number between one and five p. m., and a larger number returned to carry the work between five and seven.

The hours for the night nurse being from eleven P. M. to seven A. M., the interval between seven P. M. and her arrival at eleven o'clock after her evening meal at ten thirty, is best provided for by nurses delegated for a month at a time to serve in the same department each evening from seven to eleven. At eleven o'clock a meal is served to these nurses before going to bed and they are free from duty until the next afternoon, when at one o'clock they report to the same departments, are on duty four hours (from one to five), are off duty two hours (from five to seven) return and carry the department from seven to eleven P. M., making two periods of four hour duty with a break of two hours between.

The advantages of this arrangement are: the nurses know the departments well, are under the supervision of the head nurse in the afternoon, and doing the same duty for periods of a month provide an uninterrupted routine between the departure of the day, and the arrival of the night nurses. The fact that they report to a department at one o'clock also helps to get the morning nurses off for lunch and carries the work of the department until other nurses are able to get back at two, three and four o'clock. The advantage to the nurse who relieves between seven and eleven P. M. of putting in her other four hours from one to five o'clock, the next afternoon, is that she has all the early morning free, to rest, to attend a class or otherwise spend away from hospital duty, which in this way is grouped together between the hours of one and eleven P. M. Always, of course, there are adjustments to be made on account of extra heavy work in a department, illness or absence of nurses, or relief arranged through the office for class attendance, which cannot otherwise be planned for.

An eight-hour day means extra work and thought, and is not easy to arrange, but it has become a necessity for nurses' schools and will have to be accepted as one of the problems.

In the first experience the writer had with the eight-hour day, the student nurse worked eight hours daily for seven days a week, without weekly half days or extra time on Sunday. As not infrequently, the eight hours lengthened into nine or more hours, the supposedly fifty-six hour weekly schedule invariably ran considerably over that time; also as in cities distances are apt to be great, a short three hours did not suffice to pay visits to friends, a matinee was prohibited and even shopping was difficult. There was a monotony about eight hours each day with nothing for the nurse to look forward to. The service was not a satisfactory one and did not conduce to the happiness of the student nurse.

In the second experience, conceding likely daily loss of time, provision was made for a weekly half day and for a six hour service on Sunday, which, with allowance of three hours weekly for class work, totals a forty-nine hour week. While it is a rare thing for student nurses to get off duty at the stroke of the clock, so that the forty-nine hour schedule does not hold absolutely, yet it is a long step in advance of the fifty-seven, sixty or even the seventy hour week, where also over-time is common. The effect on the student of the effort to reduce practical working hours is most beneficial and decidedly makes for a satisfied student nurse body.

Nurses delegated for a month's time, to the hours one to five; seven to eleven, and the night nurses (eleven P. M. to seven A. M.) are not given extra time weekly, but at the expiration of the night period are allowed half a day for each week spent on night duty before going back on day service.

As it is the night nurse, who being relieved of the old time nine, ten or even twelve hour night duty, benefits most and certainly stands greatest in need of the reform, hospitals wishing to make the change and unable to introduce it at once for the whole twenty-four hours, would do well to start by making the night duty a straight period of work from eleven P. M. to seven A. M. The freedom from the hospital for the intervening sixteen hours allows the nurse to get some fresh air, a little opportunity for recreation and gives her a fighting chance to change day into night and to secure sleep in the time nomally spent as a waking and working period. Inability to sleep in the day time, long hours alone in a ward after a succession of sleepless days, meeting the varied exigencies of night duty, have proved the Waterloo of

many young nurses and lost to our hospitals women who under more fair conditions could have been made valuable. The effort to make an eight-hour night by having the nurse on duty from seven P. M. to seven A. M., with relief for rest during the night is not satisfactory, as while she may not work any more hours, she does not have the freshness of thought that complete absence from the work allows. The more or less irregular relief given the night nurse under this method, also is not satisfactory for the department.

Naturally more nurses are needed for an eight-hour service than when they worked nine, ten and twelve hours daily. However, more young women are willing to go into hospitals which maintain the eight hours and as it would seem that the time is over when these women will unquestionably accept undesirable conditions, if we are in need of their service, it is apparent that wisdom will urge the hospitals to meet their expectations and make such readjustments in work and general conditions as are necessary to adopt a consistent eight-hour service.

CHAIRMAN RIDDLE: We have here the plans for the working out of an eight hour system as carried on in the Peter Bent Brigham Hospital of Boston, which we have come to consider one of the best training schools in New England. The Superintendent, Miss Hall, has outlined their plan, which will be read by the Secretary, Miss Catton.

MISS JESSIE E. CATTON: Our day nurses are on duty from 7 until 7 with four hours off duty. They go to breakfast before reporting for duty at 7 in the morning. One other meal during the day comes out of their off duty and one comes out of their on duty time.

On each ward one or more nurses report for duty at three in the afternoon and are on duty until 11 P. M. These are called evening duty nurses. Their presence on the wards is a great help in arranging the off duty time of the regular day staff and they make the night nurses on the wards from 7 until 11. When going off duty at 11 P. M., they go to the dining room for a luncheon of milk or hot cocoa and toast or crackers before going to bed.

Night nurses are on duty from 11 P. M. until 7 A. M. They go to the dining room for a hot supper at 10:30 and are again relieved to go to the dining room for a luncheon between three and four in the morning. This luncheon consists of hot coffee or milk or cocoa and toast



or crackers. They go to breakfast after coming off duty at 7 in the morning.

We have not arranged to give any afternoons in addition to this off duty time, but without doubt shall do so within the next year. This arrangement provides something less than a 56 hour week but it is not down to the 48 hour week which has been talked about so much.

CHAIRMAN RIDDLE: Are there any questions to be asked, or has anyone present anything to offer along this line? Before passing to the next subject I would like to call your attention to an expression made near the beginning of this session, that fortunately we have little business for the afternoon. It will, however, be necessary for us to elect a chairman and a secretary for this section for another year. Will you, therefore, have this in mind, that when we come to the nomination and election of these officers we may proceed rapidly in the matter at the close of the session. If there are no further questions we will pass to the next subject, The Necessity for an Adequate and Reliable Curriculum in the Training School for Nurses, on which a paper prepared by *Miss Helen Wood*, Superintendent of Nurses at Barnes Hospital, Washington University, St. Louis, will be read by the Secretary, Miss Catton.

MISS JESSIE E. CATTON: There is still argument as to the real function of the training school in hospital organization. We must admit that schools of nursing came into being primarily for economic reasons: to provide the least expensive nursing service for the hospitals. And being well established it was soon demonstrated that where schools existed there generally was to be found better nursing and a higher esprit-de-corps than where there was no course of instruction given. Therefore, in discussing nursing in hospitals, most problems revolve themselves into problems of education and school organization.

Our early method of instructing pupil nurses was the apprenticeship system; and altho many argue that our teaching should still be on these lines, history shows that the successful schools of today—and by successful schools we mean those that are attracting the largest number and the better educated women—are those that are passing rapidly from the vocational to the professional types of instruction, that are building on a foundation of science as well as practice in preparing the nurse of today for her life work.

How can we prove this? By our observation of the fact that those nursing schools whose ranks today are best filled are those whose course of study is academically more technical or, as we say, have the highest educational standards.

The high school graduate today, or even her sister who has not been able to complete a full high school course, investigates carefully the line of work she is to take up as she leaves her high school. If she enters college, she no longer enrolls in a given institution because it has been selected for her. She has studied a half dozen college catalogues herself before her decision is made. A class of thirty probationers in one of our training schools was recently asked how many had selected that particular school without investigating others. Not one—although half the class were still under 20 years of age. Of this group, the only study of the course of nursing available to the majority was the printed circular sent to them by the Training School. That particular circular was not especially attractive—the few illustrations in it were most uninteresting; the general information as to the life of the pupil nurse was of the type that could be placed in almost any training school circular; but the general result of the study of the pamphlet on the prospective applicants was, according to their own statements, that the school therein described seemed to them to have better educational advantages than they found offered by the other catalogues which they read. And it is education that the young woman today is seeking.

Does it, therefore, not behoove us to construct a prospectus that shall be not only sound efficient from our point of view as training school organizers and administrators, but that shall also be attractive to the young woman who is trying to decide whether she shall take up nursing as against some of the many other attractive fields open to women today?

Even in high school she has learned to talk of school credits, and she likes to think that the studying she shall do in the hospital can be valued in this manner. So we estimate for her the academic value of our class work; and if in the process we begin to find that our science courses seem rather frail as compared even with the courses in the secondary schools which our prospective students have already conquered, we understand why they need building up and we begin to investigate our system

of lectures and laboratory teaching to see wherein we have been lacking.

It is important that the very brief description of the various courses should mean something to the young inquirer. Chemistry she knows. She had it in high school, never saw much sense in it, and all but failed the required work in her senior year. And what, she wonders, has chemistry got to do with nursing? A short well written paragraph descriptive of the training school course of chemistry, showing its connections with nursing, with dietetics and with the study of materia medica cannot fail to give her an academic curiosity about the study of chemistry which has as yet been unknown to her. And this same interest should be stimulated by a simple description of each study offered during the course of training.

Scarcely a student enters our training schools who does not have to overcome some prejudice at home; and we, therefore, want our prospectus to be of interest to the father and mother as well as to the daughter. Therefore, we must make clear in our description of the nursing school that the inheritance of the probationer of ten or twenty years ago—the long hours of house work—is not put upon the shoulders of the present day probationer.

More than half the parents who make inquiry in regard to our schools ask about the scrubbing of floors that they hear must be done by the young nurse. In our circulars we should go rather into detail into the daily routine of the preliminary student, describe her class work, her supervised ward practice, her hours of study and recreation, and how we look after the health of our pupils. And this should be shown by illustrations as well as by text.

Much can be said of the kind of illustrations used in our nursing school publications. Without any the pamphlet needs light and air; but we should select them more carefully than is usually done. Pictures of hospital buildings or of empty wards and class rooms may mean something to us who are in the work; but the things that catch the eye of the future nurse or her parents are pictures of pupil nurses at work and at play, taking care of their charges in the children's wards, out on the tennis courts or assembled for graduation exercises.

One more point should be shown in our prospectus: the field open to the graduate nurse, the real test of any

training school. Three years of study and practice seems a long time unless the student sees the goal; the opportunity of teachers in training schools, of executive work in hospitals, of private duty, of the various forms of public health work and most important of all—a point which is of particular interest to parents—the preparation of life, as a daughter in the home, as a mother in her own household, or as a citizen in the community that can be obtained in the three years spent in the good nursing schools of today.

CHAIRMAN RIDDLE: I have in my hand a paper which was prepared by a recent graduate setting forth her ideas of what a prospectus should be. It would seem that she is telling what appealed to the young women of her time when looking for a school which they might enter. As the time is so short, we will not have this read, but will simply say that she lays much stress upon one item mentioned in the last paper, and that is information concerning opportunities after the completion of the course as carrying great weight with the parents of those who are to enter our schools; also the statement of the fact that pupils are cared for without personal expense when ill. I will call upon Miss Wheeler of the Illinois Training School to discuss the question of the prospectus and curriculum. Miss Wheeler.

MISS MARY C. WHEELER, of the Illinois Training School for Nurses, Chicago: In the matter of the prospectus, I think it is very important indeed to take care of the mechanical side of it. The text will necessarily need to deal with your own school and what it can give, but I think we have not paid very much attention to how the thing looks; we leave that mostly to the printer. In making up a prospectus, we should take into consideration the kind of paper, the margins about our text, the kind of ink that is used as well as the pictures which are going to decorate it; whether or not there is a printed margin and what the outside looks like and whether or not, when we get through with it, it is going to be too heavy to mail for a two cent stamp. Sometimes we include in our catalogue or prospectus the names of our graduates and their residence, etc., and a great many of our prospective students do not care for the individual names. If there are a large number of names, we can put them in a separate pamphlet and send that on request. Another thing about the prospectus is that it should be followed up. An inquiry comes into our school, which means that that person

is interested or some member of the family is interested for her. We send out the prospectus and the matter then is usually dropped. I believe that we are finding that we must follow up these inquiries and so develop a follow-up method, either by card system or otherwise which will, eventually, carry on our list the woman who is perhaps below age and below in education and turn her to your particular institution. I know a great many of the young women deliberately send for ten to twenty catalogues, put them side by side, and study them. They know none of the names, but they are interested in the way the catalogue has been gotten out and I believe we should be very careful, if we are going to keep our women interested in the school, to pay attention to the mechanical side of the situation as well as giving careful attention to the contents.

CHAIRMAN RIDDLE: I would like to ask Miss Clayton, of the Philadelphia General Hospital, to continue this discussion, particularly as to the curriculum.

MISS S. LILLIAN CLAYTON, Supt. of Nurses, Philadelphia General Hospital, Philadelphia: If the prospectus is to attract students to our schools of nursing, it should show that the school is really prepared to give the education the young women need in order to meet the professional requirements of society after their graduation.

During the past two years, most of the objections to training schools that I have heard from mothers, fathers, friends of the students and from graduate nurses themselves, have been based upon the fact, that the curriculum presented by the training school does not prepare the student for the various phases of professional work required of her after graduation. The curriculum was planned to meet the needs of former days and not those of the present. The nurse is still the bedside worker in the hospital and in the home, but she must be prepared to be much more than this.

As we intelligently study the needs of society today, we find a great demand for the person socially trained. The nurse must understand preventive work as well as curative. We will find the young women uninterested in the prospectus of a training school when they become aware that the course offered does not prepare them for the broad field of service for which they are looking. In other words, if they are to be nurses, they want a complete nursing education.

A criticism frequently raised by the parents is that the prospectus does not give sufficient information as to the personal life of the student. This summer at a mountain resort, I met several mothers whose daughters were in training schools. Each of these mothers told me that when her daughter went to college, she had had the assurance that she could communicate with the dean or with someone in charge and that she would get full information as to the personal life of her daughter; that she felt much more concern for the physical welfare of her child than for the academic training. "But", said these women, "we now have our daughters in training schools and are made to feel that because nurses and doctors are in charge, we have no right or privilege to inquire as to their welfare or to plan for them." That statement came from more than one mother and it seems to me that if the prospectus would give the mother the assurance that the hospital would be interested in the social and in the physical life of her child as well as in her education, it would help remove some of the prejudice now felt by parents when their daughters wish to enter schools of nursing.

CHAIRMAN RIDDLE: I would like to ask if Miss Keith would not speak upon the nursing situation at present from the standpoint of the superintendent of the hospital? Just a few words, Miss Keith.

MISS MARY L. KEITH, Supt. Rochester General Hospital, Rochester, N. Y.: We found in installing our eight hour day and night, that the number of additional nurses required was one for each ward, that being the nurse who was on duty from 3 to 11. We have a director of recreation in our nurses' home. We took in a class of 45 preliminary students one day last week. A good many mothers and fathers accompany these young women as they come to the school, and it is our custom to have a tea for them on the following day. They then meet; the mothers meet the instructor of recreation and they establish some little contact, and occasionally they will ask if they may have a line or if they may write to the director later. On the first Sunday after these young students have come to us, the recreational director posts a notice on the bulletin board that she will take a group of nurses to some church. Those who would like to attend the Presbyterian Church, for instance, and she will meet them at such a time and such a place, and the group who prefer to go to that church, she accompanies them



and introduces them to the minister and the social secretary, if they so desire, and it has resulted in signing up for the gymnasium, and for the swimming pool. Next Sunday she meets another group who wish to go to the Methodist or Episcopal Church, and that is continued until the various denominations have all had their representation from our school.

CHAIRMAN RIDDLE: I would like to ask Dr. MacEachern if he will speak from the same standpoint on the nursing situation in general, and I would say, as I said to Miss Keith, let us hear from the standpoint which most interests him.

DR. M. T. MACEACHERN, Superintendent Vancouver General Hospital, Vancouver, B. C.: Ladies and gentlemen: I have not been given much time to collect my thoughts; however, I am going to speak to you from one or two important standpoints. First of all, in regard to the shortage of nurses, I do not believe that we have to deal with that as much as in the past years, and that hospitals are securing more applicants than a year or two ago. In Canada we have very little trouble in getting a sufficient number of applications for training. There is one condition, however, which I have observed recently, more than formerly, and that is the age of the applicants. Young women coming in to train are anywhere from four to five years younger than formerly, and when educated young women, physically healthy, of very excellent standing apply, we are inclined to take them in, though the age limit is generally twenty-one years and frequently these young women are one or two years below this requirement. Consequently we may be getting a young woman who does not assume responsibility as well as those from twenty-three to twenty-six years of age.

The second point I want to mention is the importance of the physical examination of the nurse on admission. I want to tell you that this has been sadly neglected in a lot of training schools. Miss Keith has told you about the need of recreation and a recreation instructor. A lot of your schools have physical instructors and many of you look after the health of the nurse in a careful and well guarded manner. We find a good deal of trouble with nurses coming to us prepared to go into training who are physically unfit. We demand a doctor's certificate. The family practitioner says: I have been in charge of this family for years and know they are all healthy, and as a rule put his O. K. on the application, who per-

haps later on is found to be physically unfit. At one time in our hospital we did not send a form to be filled in, but now we have a stereotyped medical report form that the doctor must fill in and sign. Further, each case is examined again by one of the hospital authorities on admission to our training school, during her first or second day. Occasionally the hospital authorities are forced to reject a young woman who has been passed by her own family doctor. In certain cases where this has happened and the girl has been returned home to her family, they want to know from the doctor why he passed her—this tends to make medical men more careful in giving certificates of fitness to nursing applicants. We used to examine them after they had served the first two months' probation, but I have changed that so they are examined by ourselves on the day of admission or the following day. Recently, out of fifty-one applicants who came in and who were duly certified by reliable doctors, two were turned down as physically unfit, one of these having come three hundred miles. I found one girl very much under weight and under nourished. We sent her home and told her to apply two years hence and we would see her then. The other girl had an extremely extensive chronic acne which had gone on for years without special treatment and had so disfigured her face and features that I was afraid it might make her approach to the patient difficult. The point I want to make with you is a high physical standard for your nurses; by examination by a family doctor and the filling in of a definite form, by further examination on the day of admission by a reliable authority of your institution.

The third point I want to make is something which has just come to my mind and it has to do with the relation of the hospital standardization program to the nursing service in the hospital. In the work of promotion of the hospital standardization program we find that we encounter certain conditions in the nursing profession that make our program a little bit difficult to carry into effect and we have realized this year that the hospital standardization program is very intimately related with the nursing service. I wish the nursing body could standardize their service in the hospital. Let me illustrate the point that I want to make. We will have a very high class and splendid institution as far as all we are asked in the minimum standard is concerned. This institution complies diligently with all that is demanded in

staff organization with analytical review of work, with records, with laboratories and diagnostic services; it may be a magnificent institution and the patients receiving to all intents and purposes a good service. There may not be the necessary oversight and supervision which is required from a competent graduate force. The undergraduate nurse changes about from ward to ward, from department to department, but she must have competent supervision. I have recently heard of a hospital where, owing to lack of competent supervision over technique in the operating room, a serious epidemic of infection followed. Investigation proved that it was due to lack of competent graduate supervision of this work. It seems almost necessary that there should be a clause in the standard which should cover the nursing service, as it is so inseparable from the scientific care of the patient. I believe that all the undergraduate nursing service should be under competent graduate supervision in order that the best results, as aimed at by hospital standardization, may be obtained.

I do not want to make any further points, but there is one thing I do want to mention. I believe in a high standard for nursing and I believe in nursing education. I do not care if the doctor comes to me and says: yes, this teaching your nurses all these things in the University is going to kill the profession. I want to tell you that in our institution the young women who are taking the University course, the higher educated young women, are practical and doing excellent work in all lines, in fact, I notice that the gold medalist last year in our hospital, which is awarded for general proficiency with special consideration of the practical side, was a B. A. I am prepared, after eight or ten years close connection with training schools, in which I have seen many scores of nurses graduate, to say that higher education is not detrimental in the turning out of a good sound, practical, competent nurse. My conferrers do not always see eye to eye with me on this matter. I believe the most difficult problem we have to solve in connection with nursing is that the course is getting so full of work that for the third year with the maternity, pediatric, operating room, dietetic services and other specialties, we must soon consider the elective course in the third year. Probably some of you have this already—it is a very difficult one to handle.

Now, ladies and gentlemen, I did not intend to speak and did not know what I was going to speak about, but this is such a big question a great deal can be said. I am interested in it, every hospital superintendent must be interested because the longer I administer hospitals and am connected with hospitals and training schools, the more I realize the importance of the nursing phase and that the quality of the nursing service in my hospital has a great deal to do with the success of my administration; and the larger hospitals can take it from me that they will do well to allow the smaller ones an opportunity of affiliating with them and thus help them along. Affiliation in our instance has been successful.

MISS MARY C. WHEELER: A good many of you have been asked recently to send in records in regard to the number of students graduating year by year from our various institutions, in order to furnish a report for the American Conference on Hospital Service. I have a large number of figures here, but I wish to say that out of the total number of schools, that is 1,585 schools written to, there were 1,156 schools who failed to give me the accurate date of organization of the school, showing that the records are tremendously lacking. Now I have asked for the school output year by year, and I can almost guess when the school was organized. May I ask that in filling out questionnaires from your records, that especial attention be given to three things; that the reports be accurate, that they be sincere, and that they be legible.

CHAIRMAN RIDDLE: We will proceed to the election of the chairman and secretary for this section for the coming year. We have known that this duty was required of us only since noon, therefore we can only nominate and elect these two officers by acclamation. I await your pleasure as to nominations. First let us consider the nomination and election of a chairman of the nursing section. Who shall act in this capacity next year?

MISS HENDERSON: I nominate Miss Logan, of the University of Cincinnati, as the chairman of next year's session.

Nomination seconded.

CHAIRMAN RIDDLE: Is there another nomination?

A MEMBER: I would like to nominate Miss Johnson of the Massachusetts General Hospital.

Nomination seconded.

CHAIRMAN RIDDLE: We have these two candidates. We will vote upon them in the order in which they were

nominated, and I shall ask for a rising vote, as I think that is the easiest. All in favor of the first nominee, Miss Logan, Superintendent of Nurses at the Cincinnati General Hospital, please manifest it by rising. All in favor of the second nominee, Miss Johnson, of the Massachusetts General Hospital, also please rise. We will announce the result later. And now may we have the nominations for Secretary?

A MEMBER: I nominate Miss Pound of Richmond, Ind.  
Nomination seconded.

CHAIRMAN RIDDLE: Any other nominations?

A MEMBER: I nominate Miss Yeager of Toledo.  
Nomination seconded.

CHAIRMAN RIDDLE: Now we have these two candidates, Miss Pound and Miss Yeager. Those in favor of Miss Pound as Secretary will please rise. Those in favor of Miss Yeager will please rise. I will ask the Secretary to announce the results.

SECRETARY CATTON: I will announce that Miss Logan of the Cincinnati General has 42 votes and Miss Johnson 28; and for Secretary Miss Pound 26 and Miss Yeager has 15.

CHAIRMAN RIDDLE: We will therefore declare Miss Logan the chairman for the section next year and Miss Pound the secretary. Another year, when it really becomes known that this is a duty of this section it can be done with less confusion and greater satisfaction, I am sure. If there is nothing further, may I remind you that you are invited to the moving picture theatre below, and the meeting is adjourned.

JOINT GENERAL SESSION OF THE AMERICAN  
CONFERENCE ON HOSPITAL SERVICE AND THE  
AMERICAN HOSPITAL ASSOCIATION

September 15, 1921, 10:00 A. M.

Dr. Frank Billings in the Chair

PRESIDENT BALDWIN: The gentleman who is to preside at this meeting needs no introduction to this body: Dr. Billings.

CHAIRMAN BILLINGS: In this joint conference between the American Hospital Association and the American Conference on Hospital Service, a program was prepared in advance and the first paper was to have been presented by John G. Bowman, Chancellor of the University of Pittsburgh. Unfortunately, Dr. Bowman is unable to come because of important duties in Washington. Fortunately for us we can fill in Dr. Bowman's place most adequately, for we have at this conference Dr. Franklin H. Martin, who is the director-general, as you know, of the American College of Surgeons, and the subject upon which he will speak is one that he is fairly qualified to talk about, the work of the College in standardization of hospitals, and that is the fundamental question with us. The splendid work the College has done in the standardization of hospitals and the experience that the College has had in that work will be taken up this morning by Dr. Martin. I have great pleasure in presenting Dr. Martin.

DR. FRANKLIN H. MARTIN: Your chairman has stated that you have a substitute for Mr. Bowman in this talk for this morning. I am aware that I will be a very poor substitute for Chancellor Bowman. However, I am interested in hospitals and I have been interested in hospitals for thirty years. I am also interested in hospitals through the work of the American College of Surgeons. The American College of Surgeons has been mentioned so often, quoted so often in this convention, mostly in favor of the College, that it has almost been embarrassing for me to sit here and listen to the discussion. The American College of Surgeons has possibly made some impression upon the hospitals of the country. If it has done so, it has done so by attempting to do something worth while.



The American College of Surgeons has only been in existence since 1913. As you know, it consists of a body of surgeons of about 5,000. It is not a Yankee association, it is not a Canadian association, it is not a North American association, but it is a continental association having membership in all of North and South America, practically every country. The American College of Surgeons at its beginning found that its duties were two things—its ideals. First, the betterment of surgery. Second, if possible, the elimination of unnecessary surgery. The American College of Surgeons in its beginning had to have some way of standardizing its own body. The first point taken up by the American College of Surgeons was an effort to standardize the surgeons belonging to the American College of Surgeons. In doing that, it immediately found that it would come in contact with the environment in which a surgeon must work. Surgery cannot be done in any civilized country now unless it is principally done in the hospital; therefore, the American College of Surgeons found that it had some way in standardizing itself, to come in contact with the hospitals.

The next thing the American College of Surgeons found was that it was necessary, in admitting fellows to the American College of Surgeons, to have some standard for admission, and we insisted that all surgeons under forty years of age who were candidates for the American College of Surgeons should file fifty case records for major operations performed by himself and fifty cases in abstract; in other words, before he could become a member of this Association, he would have to show that he did business and not simply talked surgery. In insisting upon these fifty records, we soon found that the records were coming in in all kinds of shape. They did not put them on their cuffs, literally, but it was almost that, on pieces of newspaper, on pieces of writing paper—all kinds of forms of records. As long as those records show that the man was doing the business, and in our verification of those records, we found that the records corresponded with what the man had been doing, we were satisfied with the records and passed upon the records as they were; but it was soon evident to us that it would be necessary, or at least convenient if we could have some uniform system of records. That was the beginning of standardization.

We hadn't any idea of going into the hospitals, of making surveys of hospitals, or anything of the kind; we simply asked that we have, or stated that it would be

convenient if we could have some uniform system of record. That brought about the formation of a committee of specialists and we made a form or record; not a form that we insisted upon any hospital using or any one of our candidates using, but simply a form that could be copied if they desired to copy it. The hospitals soon began to ask, those that did not have records, began to ask for copies of these forms and we sent them copies of these forms. They then asked for other requirements that we made for hospitals in which our doctors did their work. We told them that we had no requirements, we simply asked the doctor to make good. That was the beginning of standardization. It was not an attempt to interfere with somebody else's business, to get in and spy upon the hospitals of the country; we simply attempted to furnish an environment in which surgery could be properly done.

Then the hospitals at the beginning of the war began to ask us to furnish some little standard that they could follow; that is, those hospitals who were not far beyond our minimum standard already. That resulted in a committee meeting being called in Washington, and in connection with the Army and Navy and public health department, a conference was held and certain minimum requirements discussed, and it was at least six months after that before the American College of Surgeons decided that it would be convenient for the American College of Surgeons to analyze some of the hospitals in which the surgeons were doing their work. It was fully a year after that before the minimum standard was stated.

What is the minimum standard that there has been so much discussion about? Do you realize that a hospital could not exist and be a hospital and not meet that minimum standard? Records—no one will question that at the present time. An organized staff of honest men—nobody would question that. Laboratories for diagnostic purposes—no one would question the necessity of that. Now that is the minimum standard of the American College of Surgeons.

The hospitals were so greedy to cooperate with the American College of Surgeons in this work that they asked us to visit them and see if they were meeting what our requirements were. Reluctantly we accepted that invitation, but before doing so we did this: we went to the great mother association of the country in medicine and stated that it seemed desirable that something should be done along that line and asked the chairman of the committee

on education of the American Medical Association if the American Medical Association would not attempt to do this particular thing. This was a personal interview. The matter was reviewed and it was found that the American Medical Association was interested in hospitals to the extent that they would decide what hospitals should be acceptable for internes. We then said "Is there any objection to this other program being put through." "No, it would be a good thing." "Will you do it?" "No, at present we are not in a position to do it." "Have you any objection to the American College of Surgeons attempting it." "Not at all, go to it." Therefore, the American College of Surgeons accepted this little program of standardization.

Why were we asked to do this and why were we interested in doing it? First, in order to standardize the environment in which surgery is done. Why were we asked to do it? Because we were able—happened to be at that time in a position to finance the undertaking. Those were the two reasons. Our program has been, as you know, to survey the hospitals and to ascertain what hospitals were meeting the minimum standard. We have no authority whatever except the authority of the ideal.

The way the program of the American College of Surgeons has been accepted is an indication that it was something very much desired by the hospitals. Now why? First, because the surgeons wanted it—a small group of surgeons. Second, it was very apparent that the medical men required it just as much as the surgeons required it. It was very apparent that the people who were hospital patients required it more than any of them, and it was very apparent that the hospital superintendents were getting tired of simply running boarding houses for patients into which were dumped all kinds of cases by all kinds of doctors; and they immediately accepted the standard.

The difficulties of the survey were not as great as we expected they would be. Who are our surveyors? They are young men graduating in class A schools who have had an internship or a house officership in one of the leading hospitals of the country connected with a class A school. In the last three years we have probably had thirty, possibly thirty-five, of these young men doing this sort of work. What are our instructions to these young men? Let me read the instructions given to these young men as they start out—a portion of them: "The

visitor is a member of the visiting staff of the college. The impression he creates will affect in a large measure the reputation of the college; it is needless to say, therefore, that his personal appearance, deportment and dignity with which he conducts himself are matters of great importance. The attitude of the visitor should be that of collecting facts in a kindly manner. He is not a detective, an unbidden critic nor a social caller; his mission is business in a businesslike way. Comparisons of institutions are not his purpose; the motive of his visit is facts. He collects them, and when acceptable he presents other facts in return. The success of his visit will depend upon his personality and his sincerity. One cannot, day in and day out, merely simulate sincerity.

The visitor must believe in his work; if he does not, he should quit. The results of his visit are in the impression he leaves behind him. The visitor who is unwelcome has in all probability not handled the situation properly in regard to the manner of his approach to the institution. The American College of Surgeons began this survey there years ago. It began it with the 100 bed hospitals, visiting the 50 bed hospitals or 100 bed hospitals in number whenever it was convenient to do so; but the survey was made on the 100 bed hospitals, 697 of those hospitals in the United States and Canada in 1918-1919, and eighty-nine out of this number of hospitals met the minimum standard. Now that is a reproach, it seems to me, upon the hospitals as they existed at that time. Those three things, all that I have indicated. Eighty-nine met that standard.

The next year 198 met the standard. Last year 407 out of 697, or considerably more than half, met the standard or agreed to meet it. Some of them were visited and were found lacking and they promised to make good and afterwards said they had made good. Those hospitals were starred and put on the accepted list under a star. This year we hope, and those figures I think, will be backed up by our Canadian representative, Dr. MacEachern, that the number will be nearly five hundred and fifty out of the seven hundred. Dr. MacEachern, I believe, thinks the number of standardized hospitals in the one hundred group will be more than that, but I rather doubt it.

During this year and last year a large number of the fifty bed hospitals were visited and next year in the report the fifty bed hospitals will be included.

At the beginning of this work we found quite a little suspicion directed toward us. "What is the American College of Surgeons doing this work for? What business is it of the American College of Surgeons whether we have an honest staff or the sort of staff that we have? What business is it of the American College of Surgeons if we have records or if we do not have records?" Those criticisms were probably rather few, but like all criticisms they made more of a stir than the silence that approved of our program. This criticism is now being changed to a receptivity on the part of the hospital. Every time we make a visit anywhere, any of our surveyors, whenever we have a meeting anywhere in the United States, we are besieged by hospital superintendents of hospitals of fifty beds and over asking "When are you coming to us? We cannot do anything with our trustees or we cannot do anything with our doctors until the American College of Surgeons helps us;" and it is understood that the hospital that is not standard will not be on the list next year. That sort of thing is what we are receiving at present, inquiries for help along the same line that we have been trying for help in reference to the larger hospitals.

The American College of Surgeons is spending a great deal of money on this proposition. This year our report will show that \$64,000 has been expended since August of last year to August 1 of this year on purely standardization work, not counting the overhead. In reality, counting the part of the work that has been done in the state meetings of the college, we have spent over \$105,000 in that time in this standardization program. Now what are we going to do in the future? We have got to finish our job. We have taken a responsibility or it was thrust upon us and there is no other way than that we should finish it, and we propose to continue with the survey this year and next year, and then what? The American College of Surgeons, remember, started this program for the standardization of surgery, the medical profession, surgeons particularly. It cannot at any time in the future relinquish the standard that applies to surgeons especially, to other activities. Therefore, the American College of Surgeons, while its standardization, its survey, may be over in two or three years, it will be necessary for the American College of Surgeons to always be interested in hospitals.

Mr. Chairman and hospital superintendents and doctors, our worthy chairman here got himself more or less embarrassed at one time recently by stating—I am not going to try to quote his language, but I will simply give the impression—by giving the impression that he felt the inevitableness of more or less control of medicine by the government. The governments have been—municipal, county and state—have been gradually taking over, without our really realizing it, for a good while, many of the activities of the doctor. Many doctors are now on salaries working for the government in various ways. More and more this thing is coming.

When the war came we had difficulty, you remember, Mr. Chairman, we had difficulty to get the labor organizations to accept the draft. And do you know why? The principal reason was because they had to have a medical examination and it was going to deprive them of their personal liberty. Mr. Gompers and the conservatives of the American Federation of Labor fought for one month while General Crowder's bill was going through Congress, to get the American laborman to yield that point; and they yielded; and what is the result? They had their examinations. Thirty-three per cent of them were found ineligible because of slight defects, many of which could be remedied, and those who passed the examinations and went into the service found what? They found that they were under the advice of scientific medicine and that they were kept well and were not treated to keep them well but were directed in general health sanitation in common sense ways. They found that when they were treated, they were treated by specialists; that the medical department of the army was divided into various specialties and that they were treated under team work; that is, the pathologists did the pathology and it was done; the x-ray man did the x-ray and it was done; the medical man made the physical examination and he did it, and if an operation was necessary, it was done by a surgeon. Now the people, the men who went to war, are saying "Why in the devil can't we have that same thing given to us now that we are out of the war?" They opposed the whole thing at first; now they are in favor of being treated by scientific medicine and as far as possible by group medicine.

Medicine is becoming so scientific that it requires a longer period to succeed in getting a diploma, and therefore we have fewer doctors. What does that mean? It means that we have got to quit this old practice of medi-



cine that might be called the corner grocery practice of medicine, the retail practice of medicine, and adopt wholesale methods. And that is what we are doing in the hospitals; the hospitals are furnishing the laboratories. The hospital is furnishing the group of men to do the work, not necessarily a group bound together but a group of men who cooperate. The hospitals are furnishing the honest staff and the whole plan is the wholesale medicine of the future, and if scientific medicine, Mr. Chairman, does not direct this business of state encroachment, we will have medicine in the future carried on by sanitarians graduated from cess pools examiners instead of having it carried on and directed by the great medical profession.

One more word; the American College of Surgeons, besides preaching minimum standard hospitals, is preaching one thing more, that all the great medical societies naturally are for, that scientific medicine is the medicine that should direct all of these things, and that if scientific medicine directs all of these things, the adventurer, the blue-sky man, the quack, will have to go by the side. As I heard the secretary's report the other morning I realized what an enormous organization this organization is; I realize what an enormous work this organization could do in propagating just that thing, scientific medicine. At the quiltings, at the women's clubs, at all of these places the women should be infected with the idea of scientific medicine. Let them make scientific medicine the fad. There is so much in scientific medicine that it can easily become a fad because they never can conquer it and compass it. This Association has not financial backing enough. Think of the thousands of hospitals you have in this country; think of what it is worth to a hospital of one thousand beds to have an organization of this kind back of it in its problems. Its dues should not be less than one hundred dollars to this organization; the dues of five hundred bed hospitals should not be less than fifty dollars; all other hospitals, twenty-five dollars; and every one of us working in a hospital, surgeons, trustees and all others, should pay a ten dollar fee to this organization. If that were done and other financial things followed up, that would make that thing popular. The American Hospital Association can do more to stave off the thing we dread, state medicine, more than any other one organization.

CHAIRMAN BILLINGS: In behalf of the joint conference I want to extend to Dr. Martin our thanks for coming here and filling the breach and presenting this very interesting statement to us. No word of comment is necessary from your chairman as to the character of the work done by the American College of Surgeons, in its program of standardization of hospitals. The work speaks for itself; the results of the work are manifested in the acceptance by so many of the hospitals that have been surveyed, of the minimum standard, and in the improvement of the professional work and particularly the surgery of those hospitals.

I want to say a word of comment concerning the later remarks in reference to the government's relationship, either federal or state government, to medicine or to welfare work. There is alarm in the minds of many of the medical profession that paternalism is to be an adopted policy of the government and of the state. I believe that that alarm has no fundamental grounds upon which to stand. During the war when we had military discipline, the government was able to function, to centralize and also to decentralize and to do efficient work in behalf of soldiers in service and in the operations of the draft; but when the government assumes a policy of welfare work in peace times and without military discipline and especially when it centralizes that work in Washington, the results are so disastrous, so inefficient, that we need have no fear of paternalism in our government.

It has been my fortune to work in Washington this summer in behalf of the disabled soldiers and the amplification of hospitals for them. I need only say to you that in the benefits accorded by the government to disabled men, which have been so woefully administered by the government, that the chief fault has been due to centralization in Washington, and all centralization efforts of welfare work will result in just that way. We can all look forward with hope that the little hospital of twenty-five, fifty and one hundred beds in the country and the bigger hospital in the city, if it is properly organized as to its staff, both medical, nursing and otherwise, if it is properly administered, if it gives service to the community, that it will give a more efficient service than state or federal government can possibly give. It is an axiom in welfare work, that welfare work worth while must be paid for and must be done by the people benefited. That is

axiomatic. I do not know whether Dr. Martin felt alarm as he spoke but I haven't any.

DR. MARTIN: Not at all.

CHAIRMAN BILLINGS: I will not ask for discussion upon Dr. Martin's remarks now. Later, after the next paper, those who desire to speak upon the subject of Dr. Martin's remarks, will be at liberty to do so. We have with us today, by invitation, to read a paper, Dr. Franklin R. Nuzum, medical director of Santa Barbara College Hospital, Santa Barbara, California, who has traveled all this way to give us a message. The subject of his paper is A Method of Increasing Medical Efficiency Within the Hospital. Dr. Nuzum.

DR. FRANKLIN R. NUZUM: Mr. Chairman, ladies and gentlemen: Dr. Martin has just made it very clear that private competitive practice is not satisfactory at the present time. He has given you the reasons why group practice as it is being developed, is superceding private competitive practice, and he has intimated that the hospitals must take up the same thing, that they must not continue to be, as they have been in the past, places where one man may bring his patients and do as he chooses, but they, too, must offer the same facilities for group work that are offered by group organizations outside of the hospital; and this paper is a suggestion as to one method by which hospitals may effect such a program.

Outside of the hospital, agencies have developed whose aim is the uplift of medicine. The American College of Surgeons, at the instigation of and supported by the Carnegie Foundation for Medical Education, is conducting a standardization of hospitals throughout the United States and Canada. By effecting a "minimum standard", with all that is thus implied, a great impetus has been given better medicine. The Council on Medical Education and Hospitals, of the American Medical Association, is doing an excellent work in weeding out, classifying and elevating the standard of medical schools. They have likewise undertaken the work of hospital standardization, and have given special emphasis to hospital essentials as regards interne training. In California the League for the Conservation of Public Health, with Dr. W. E. Musgrave as Chairman of the Section on Advancement of Medical Education and Science, is making an extensive survey of hospitals. Within the past year the American Conference on Hospital Service has been organized. These,

and others which I have not mentioned, will intensify the work that is now well under way.

But, within the hospital, there has been no special agency or department whose chief duty is the elevation of the plane of medicine practiced in that institution. A debate has just arisen among hospital authorities as to whether hospitals should remain only "nursing hospitals", disregarding entirely and having no word concerning the medical welfare of the patient or whether they should aim to be "medical hospital", institutions that follow the patient's progress, literally guaranteeing that every patient shall receive medical treatment. By common consent three functions have long been attributed to hospitals: (1) the care of the sick; (2) the education of future personnel, (nurses, dietitians, administrative officers, laboratory technicians, internes, etc.); (3) research and pure science. If hospitals are to attain a high degree of efficiency in the execution of these functions, it would seem imperative that they become medical hospitals in the true sense. They will then be taking a part in the advancement of medicine. Their position is such that they can become foremost among the agencies which are aiding in this advance.

Up to the present time, few hospitals have made any effort toward becoming medical hospitals; nor is there any routine procedure to be followed in assuming these new duties. This paper is a suggestion as to one way in which this plan may be accomplished.

There should be established within the hospital an agency entirely free from the routine matters of hospital management, whose chief duty is the prosecution of a never-ending campaign for better medicine in that institution. For this work the full time service of a medical man should be procured, who, for want of a better name, may be called a Medical Director.

The modern hospital aims to provide the laboratories and equipment necessary for thorough work as regards diagnosis and treatment. Laboratories, however, are valueless unless manned by trained technicians or medical men. Since the attending staff has neither the time nor technical skill necessary for such work, it becomes the duty of the hospital to provide such help. This at once places that hospital in the class of "medical hospital." Nor does its duty end there. Granted that the hospital offers the services of chemical, pathological, bacteriological, roentgenological and clinical laboratories, with per-

sons competent to make and properly evaluate the various tests, there is yet no surety that the patient will benefit from their use. The physician, if unfamiliar with certain methods, will not use them because they do not occur to him. The hospital should have some one whose duty it is to direct attention to those methods and to the benefit that may accrue to the patient from their use. Here is where the duty of a Medical Director begins. With the laboratories well equipped and operating smoothly and efficiently, as they are apt to do when a responsible person is at their head, he turns his attention to the practicing physician. He effects a proper staff organization with its various sub-groups. He brings before them regularly the various medical and surgical problems that arise in the institution. He keeps in touch with the especially ill patients in the house and with those in whose cases it is difficult to arrive at a diagnosis. He discusses the situation with the attending man, offers suggestions if possible, and advises further consultation, if indicated. The accomplishments of a smoothly functioning staff, with team-play developed to a high degree, with its members aiding each other by suggestion and example to obtain from the laboratories and other equipment all the help possible in diagnosis and treatment, would certainly stand out in sharp contrast to the manner in which physicians practice in most hospitals at the present time. The co-operation and spirit of helpfulness which it is possible to establish among the members of a staff, especially when one man, such as a Medical Director, makes it his business to effect such harmony, results in the creation of a post-graduate school in that institution. One profits by another's mistakes. Consultations are desired rather than shunned. The various members take the time to observe the work of a fellow-member, either in the operating room, the delivery room, or the medical ward. Each man soon finds himself giving more thought and study to his patients. As a result fewer laparotomies are performed, with the removal of an appendix, an ovary or a tube, only to find later that the seat of the trouble is elsewhere. Nor, on the other hand, is a patient likely to be kept on medical treatment over a long period of time, when surgical intervention would hasten his recovery. Nor is a perforated gastric ulcer, an appendicial abscess, or an obstruction of the bowel left undisturbed when immediate surgical interference is indicated.

Such a staff would eliminate the competitive element of present day medicine within the hospital. In its place would be substituted the newer ideas of specialization, team play and thorough, intensive study of individual patients. These ideals are spreading rapidly throughout the country, because better service is rendered the public. Since the chief aim in the practice of medicine is to give better service to the sick, thereby establishing in the minds of patients a feeling of gratitude for the service rendered them, it stands to reason that the hospital which can offer this type of service, and which can bring to bear throughout the community a high degree of satisfaction and confidence in its work, is bound to thrive. It will, furthermore, serve as an educational institution in that community—a thing most needed to combat the propaganda of state medicine, social insurance and the numerous quacks.

Another of the difficult problems of the day is that of effecting a plan whereby the newer procedures in the practice of medicine may be taken up more quickly by the practitioner of medicine. Even after an excellent procedure has been worked out in the experimental laboratory, and its application to clinical medicine has been definitely established, there is a lapse of a long period of time, usually of years, before it is adopted by the profession at large. Here is another opportunity afforded the Medical Director. He has established a library in the hospital and through a Journal Club or some similar agency, the literature in a large group of Journals is abstracted and discussed at regular intervals by the staff. He suggests that certain of the newer procedures be tried. He provides the equipment, and trains a technician if necessary. The method thus tested will soon demonstrate its worth. If it is of no value, it can easily be dropped. If it is of value, that group will profit by its use over a period of several years before they would otherwise have become familiar with it.

The advancement of research and pure science, the third field of endeavor of the medical hospital, has a value so well recognized that it calls for no discussion here. Such an undertaking can only succeed when under the direction of a man qualified for that work. Since most hospitals have not recognized their opportunity in the field of research, they have naturally made no provision for such a person on their staff. A man qualified to direct the work of such a department could very well maintain his interest and technique in clinical medicine by his work



with the clinical laboratories and staff as about outlined. He would not only be taking advantage of something that would add to his own training, but he would be adding to the efficiency of the hospital by the splendid service rendered its patients, and he would prove a boon to the individual members of the staff, since they would become abler men. And while his own work with the staff has great possibilities, yet his greatest opportunity would lie in the research department. The good that results from better medicine in the hospital would benefit the community. The efforts of intensive investigative work carried out through a period of years might result in medical progress that would have a far-reaching effect.

The financial question comes to mind at once in considering this scheme of adding a new agent to the hospital staff, but the benefits that may be derived from the efforts of such an undertaking warrant the additional financial burden. Two means of financing such a department come to mind. In one instance, the fees collected from the laboratory work, after the latter was reorganized and the attention of the staff had been called to the importance of routine laboratory tests, very nearly bore the expense of the new undertaking. A second method lies in interesting some philanthropic individual who will personally meet the added expense. Hospital deficits are due largely to the care of the poor and unfortunate. The care of these people is the duty of the city. There is no more reason why philanthropic individuals should relieve the tax-payer of this duty than relieve him of street improvements, etc. What the philanthropic person should do rather than to endow charity hospitals, is the thing which the tax-payer at the present time will not do: i.e., advance knowledge by research and investigation, and furnish care for a certain group of patients that require intensive study in order that progress in the treatment of their ailments may be made.

The first instance that I am aware of in which the idea of a Medical Director was tried out was done at the suggestion of a layman who conceived of the possibility for good in such an undertaking, and who, unsolicited, financed the plan.

In conclusion, hospitals should represent the best in medicine and surgery. Outside of the hospital, specialization, group practice and health centers are becoming popular because they are an advance in the demand for better medicine over the family physician and competi-

tive practice. In order to be progressive, hospitals must meet new conditions as they arise. The time is at hand when a patient entering a hospital should have an assurance that he is going to receive careful study and adequate treatment. This cannot be done under the regime of a nursing hospital. It means that hospitals must become medical hospitals and that there must be in their organization the same elements of team play and cooperation among the various specialists and men on the staff that obtains in group medicine outside of the hospital. How best to increase the medical efficiency of a hospital is an open question. One method of accomplishment is herein outlined.

A full-time salaried medical man, who may be called the Medical Director, is added to the hospital staff.

He is responsible for the efficiency of the laboratories and should offer to the attending physician a very complete laboratory service.

He effects a staff organization in which team play, efficiency and cooperation are outstanding features.

He has charge of the research laboratories.

As a result of the blending together of the efforts of the staff and hospital personnel, the individual patient will receive better service. Since service to to patient is the standard by which medical organization is judged, that institution will soon have its reputation spread abroad and will profit thereby.

In undertaking such a plan as this, the hospital will be assuming its responsibility in the ever present demand for better medicine.

#### References:

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A. R. Warner—Modern Hospital—1921, 16, 325.

- (2) Future Medicine—W. J. Mayo, Jr. of Amer. Med. Assn.—1921, 76, 875.

- (3) The Future of Private Medical Practice.—Dr. Frank Billings, Jr. Amer. Med. Assn.—1921, 76, 349.

Dr. A. R. Warner, June 1, 1921.  
22 East Ontario St.,  
Chicago, Ill.

Dear Dr. Warner:

Attached hereto you will find a copy of the paper written by Dr. Nuzum which I mentioned to you yesterday.

I have just written to Dr. Nuzum requesting him to permit his name to be placed upon the program of the Conference under the subject of this paper. That is, provided it has not been published. I told him that if he was not able to attend I will read the paper or secure someone else to read it.

I am sure you will agree with me that the paper presents an important phase of hospital betterment and that its presentation at West Baden will be of distinct value in the program of hospital betterment.

Very sincerely yours,

FRANK BILLINGS

CHAIRMAN BILLINGS: Before I open this subject for general discussion, I want to make a remark about the hospital work, especially after what Dr. Martin said and what Dr. Nuzum has said about hospital care as being so necessary for efficiency. I agree with what they say about hospital care and that, when made efficient, it is the ideal care, but if we expect to place in the hospitals all the patients of this country, we are dreaming. I will give you some approximate figures. Approximately, the minimum morbid incidence or morbidity in the United States is 20 per cent. We have one hundred and seven million people; that gives us about twenty-two million people annually who require medical treatment, approximately 80 per cent of the people who are ill may have a proper diagnosis made without the utilization of many of the refinements in diagnosis that are necessary in a hospital. In other words; we ought to provide facilities for diagnosis, to be of use to the practitioners and in the hospitals, for about four million four hundred thousand of our patients annually; the remainder can usually have a diagnosis made and appropriate management instituted without the use of so many elaborate things. In other words, the practitioner of medicine, with the weapons or with the instruments that Nature has provided him, plus some simple things that are always available, can make the diagnosis in 80 per cent of the cases; 80 per cent of the people who are ill will not require hospital care. That leaves four million four hundred thousand annually that ought to have hospital care in this country. I want you to bear in mind those figures. Then if we, in our program, dream of hospital care for everyone, we want to wake up; we are going to wake up some day and find it is a dream. If we do anything in our program of improvement of hospitals which means the relegation of the

practitioner of medicine to the rear and a diminution in domiciliary visitation, we are making a big mistake, for domiciliary work is fundamental in welfare in this country; you must preserve it; and in our hospital program, what we ought to look forward to, is to place in communities for the treatment of the patients who require them, hospitals with diagnostic centers for the use of the practitioner, but he will have to do the work himself, and especially must he carry on the domiciliary visitation, which is not only fundamental in the care of the sick and injured, but in prevention. That is what we must get at. I want to put those thoughts before you in opening up this discussion, because I think a lot of us are confused about hospitals and the need of hospitals for all patients. The subject is open for general discussion.

I will not call on any particular individual but will ask you to discuss the remarks of Dr. Martin and the paper of Dr. Nuzum. The points put forward by Dr. Nuzum are new; it is not a new departure; it is in those hospitals of a moderate number of beds, where residents cannot be obtained, where the hospital is not large enough or is not rich enough to support residents in surgery and in medicine, that a medical director exists to coordinate the professional work, to make available not only the laboratories, but to enable the staff to thoroughly appreciate and to make the laboratories available for every day practical work. That is one of the main points in his paper. In large hospitals, where there are residents, medical and surgical, the medical resident does that thing for the medical side and the surgical for the surgical side, but that is usually only in large hospitals and teaching institutions that those things occur. What Dr. Nuzum has brought forward is for the small hospital, to carry out the standards of the American College of Surgeons with greater efficiency.

MR. JOHN M. DODSON: Mr. Chairman, in the effort to improve the character of service in hospitals of all sizes, but particularly in the out-lying hospitals, those not in the large cities and not connected with teaching centers, I have this suggestion and that is, that the sooner such a hospital becomes a study and a teaching center for the practitioners in the neighborhood, the sooner it will improve the domiciliary practice to which Dr. Billings has referred, and it will the sooner improve very greatly the character of its own staff and the service they are rendering.

ering in the hospital. Nothing is such a stimulus to good work as teaching.

We have in this country three groups, three general types of practitioners who are seeking to do advanced or continuation study. First, true graduate work of research type. That can be done only in large universities and research centers. Second, the group of men who are seeking to become specialists, to devote themselves exclusively to special lines of practice, preparing therefor by a term of special study of not less than two years. These two groups can be taken care of only in well organized schools, and if the present medical schools, undergraduate and post graduate, take care of those groups properly, they have their hands more than full. There remain, third, the great group of general practitioners all over the country who feel the need very keenly of *brushing up* courses of from six weeks to six months in some place where they can have the benefit of a library, of laboratory facilities and clinical material, and of the aid and advice of older men—of more experienced men—in special lines.

To my mind the solution of post graduate or polyclinic work in this country is the organization of three or four hundred hospitals, each of a hundred beds or more, into study centers for these practitioners. Now what shall they teach? If they continue to do as most of the previous graduate schools have done, make their work consist largely of the exploitation of the surgeons in surgical operations which the general practitioner is not fitted to do and never intends to do, they will fail of their purpose. What the general practitioner needs is an opportunity to study anatomy and to refresh his knowledge of that subject, to study physiology and physiological chemistry and pathology, methods of conducting autopsies—the fundamental things.

Nothing will improve the character of the service of the men on a hospital staff so much as to organize themselves into a teaching body to teach just these things to the practitioners in the neighborhood of the surrounding country. I look to the time in the near future when every progressive outlying hospital of one hundred beds or more will organize itself into a school; a place for the continuation study of the general practitioner, whose main need is in these fundamental branches and in the every day things which he does, and not in attempting to teach him or show to him the operations along special lines which

he never expects to do and which he ought not to be allowed to do even if he did want to.

DR. A. V. THORNTON, of the American Hospital, Chicago: I want to supplement Dr. Dodson's remarks. For nearly two years we have put into effect in our hospital the plan which he has mentioned here. We organized a clinical teaching staff, and each day at eleven o'clock during the week we hold a teaching clinic. This is conducted by members of our staff and by some of the ablest men of the city who come to our hospital occasionally and there we gather together an average of twenty-two men each day who consider those topics that are before the hospital during that week. This teaching clinic is in charge of a director who sees that these lectures are properly supplied.

This gives an opportunity to our weaker men to bring in their cases and place them before this clinic. A discussion by our abler men and the direction of the youthful minds of the younger members of our staff is leading to splendid results. I do not feel that we need to go outside of our own circle, otherwise, to some post graduate school. We can have a continuous performance of a post graduate school within our own hospital. This develops, first, our own men, and it develops our interne staff, it develops our nursing staff, and in this way, during this period of two years that we have been conducting this plan, we have found a great advance in efficiency in our hospital. I want to say to you that outside men are drifting into the hospital to get the benefit of this form of teaching.

DR. WILSON, of the New York Health Department: I think the members of the American Hospital Association owe a great deal to Dr. Martin and the American College of Surgeons for an opportunity to hear the very clear exposition of what the College has been doing in the way of standardization in hospitals. I feel, however, that the American College can help us a great deal more if they will keep urging the medical men in our staffs to get up that part of the minimum requirements that belong to them through the American College rather than through the hospital superintendents. For my own self, and I think I speak for many more or the feelings of many more, at any rate, it is with great difficulty that we can get our medical records, our histories. As a matter of fact, that is not administrative in the hospital, only so far as seeing that the records are properly collected. The great difficulty that we have in meeting the minimum re-



quirements as recommended by the American College of Surgeons is in getting our medical records, and there we must depend upon the American College to help us. They do help us a very great deal; but I am sure that every member of the American Hospital Association who listened to Dr. Martin's talk will go away with a great deal of satisfaction in his mind and heart over it.

CHAIRMAN BILLINGS: Are there any further remarks? Dr. Martin, do you desire to say anything in closing?

DR. MARTIN: In regard to the cooperation of the medical men, I take it that the last speaker refers to medical men, other than surgical men in contra-distinction to the surgeons. Now I am sorry to say that our experience has been that we have had more trouble with some of the old surgeons operating in the hospitals than we have with the medical staff, medical men, pathologists, internists, pediatricians, etc. Just why that has been, I do not know. Yesterday, I heard for ten minutes an argument on the part of a man who belongs to the American College of Surgeons against the high standard of nursing, and it was something that, as far as his hospital was concerned, he said they did not propose to meet. Now we have no authority to ask any hospital to meet any standard. We only have the privilege of putting down on paper once a year those hospitals that we feel do recognize the minimum standard. While it has no authority, that seems to have a whole lot of influence on a whole lot of hospitals, judging from the efforts that they are making to appear upon that list. Therefore, to answer the question in regard to the medical man and the surgeon, I believe that the medical man and the hospital superintendent, the pathologist, are really as anxious, if not a little more anxious, to meet this higher standard than some of the surgeons.

CHAIRMAN BILLINGS: We stand adjourned.

## GENERAL SESSION

September 15, 1921, 8 P. M.

President Baldwin in the Chair

CHAIRMAN BALDWIN: The first item on the program tonight is the report of the special committee studying flooring materials for hospitals, Frank E. Chapman, Chairman.

MR. FRANK E. CHAPMAN: The report of the flooring committee is merely a reiteration of the statements made in the Construction Section day before yesterday. Through unavoidable reasons, the preliminary data that was necessary in the analysis of hospital floors was delayed until about three months ago, and it has been necessary to do quite a good deal of preliminary work prior to the sending out of the questionnaire to the hospitals of the country. It is the hope that when this questionnaire is sent out, that each of you will give it as much time and consideration as you possibly can. The questionnaire, I say to you very frankly, is elaborate; it will tax the ingenuity of those who have not been trained to think in analytical terms. I admit all of these things, but a submissal of the questionnaire to a great many people at the convention has brought forth the reaction that it is not possible to get that questionnaire any simpler and to obtain at the same time the amount of information that is desired. I realize that questionnaires are the banes of our existence, but I am going to ask your very kind cooperation in filling out this questionnaire to the end that the results of a complete opinion of the hospitals of the country, and the results of the laboratory tests of the materials that will be selected will be available for your consideration, I hope, not later than ninety to sixty days from now. I am sorry not to be able to give you a more complete report.

CHAIRMAN BALDWIN: Next is the report of the special committee on the subject of the Relation Between Hospitals and the State and City, John E. Ransom, Chairman.

MR. JOHN E. RANSOM: An inquiry into the relationships of states and cities to hospitals and dispensaries was initiated by one of the members of the Association. Because of the seeming value of the material obtained and because of the importance to the hospital world of

bringing together the gist of the laws, ordinances, rules, regulations, etc., which affect the establishment and operation of hospitals and dispensaries, the Trustees of the Association decided to appoint a committee to bring in a report on this subject to this meeting of the Association. An inquiry was sent to the State Board of Health in each of the forty-eight commonwealths, asking these questions: "What control if any does the State Department of Health exercise over private hospitals and dispensaries? Does any other state department have control over such institutions? Should the state through its regularly constituted Health authority have control over social institutions through licensing or supervision in relation to standards which might be set up by law?" Replies were received from forty-eight states. In sixteen states the State Boards of Health have no relationship whatever to the hospitals within those states. In other states, certain authority is exercised over certain types of hospitals but none over other types. In some states, hospitals and dispensaries are operated under state licenses and are subject to state inspection. In many states there is some regulation of hospitals through regulation of nursing education. In those states in which the requisites for licensure to practice medicine includes a fifth or interne year there is developing certain control by state boards of licensure of hospitals affording interne training. A letter of inquiry, similar in nature to that sent the State Boards of Health, was addressed to the Municipal Health Departments in all cities of the United States of 50,000 population or over. Replies have been received from sixty-three cities located in twenty-nine states. Twenty city health departments replied that neither they nor any other department of the city government exercised control of any kind over the private hospitals and dispensaries located in their respective jurisdictions. In some cities, regulation is limited to the control of contagious diseases and matters of building and sanitation. Some city boards of health act as agents of the state boards of health in relation to state regulation of medical institutions. Other cities have elaborate ordinances regulating the operation of hospitals. From the information obtained by the committee it appears that hospitals and dispensaries may have relationship to the state or municipality in which they are located through

Boards of Health  
Boards of Charity

Boards of Public Welfare  
Building Departments  
Fire Prevention Bureaus  
Factory Inspection Departments  
Boards of Nursing Education  
Boards of Medical Licensure

A detailed report giving in summary form the ways in which city and state governments exercise a degree of control or supervision over hospitals and dispensaries is in process of preparation. Before it can be completed, additional data will have to be obtained from some of the states and cities under consideration. For the purpose of completing its collection of data and of placing in the hands of the association a comprehensive report on this subject, the committee recommends its own continuance for the short period of time that will be needed, to complete that work.

CHAIRMAN BALDWIN: The report of the special committee studying Hospital Forms and Records is next in order; Dr. A. C. Bachmeyer, chairman.

DR. BACHMEYER: The report of the special committee appointed to study hospital forms and records has been submitted in detail during the session of the Administrative Section. There will be, therefore, no further submission of that report except to submit to you at this time the motions which were acted upon in the Administrative Section yesterday for adoption by the General Session.

At the evening meeting of the Section on Hospital Administration, it was recommended to this session that the report of the Committee on Hospital Forms and Records be accepted, adopted, and the committee continued; that the Association express its gratitude to the generous non-member whose contribution made the report possible. That comes to this session as a motion duly made and seconded.

(President Baldwin put the motion and it was unanimously adopted.)

DR. BACHMEYER: At the afternoon session of the Administrative Section, two papers were presented, and following their presentation a motion was adopted by the Administrative Section which comes before this general session for action. The first motion was that following Dr. Emerson's paper; that the Committee on Records and Forms of the American Hospital Association enlist the cooperation of some organized hospital group or groups in the reporting, at stated times of hospital morbidity

statistics. In explanation, I may say that Dr. Emerson brought out the fact that at the present time the morbidity statistics that were being collected were those pertaining to communicable diseases, to industrial health hazards and otherwise the mortality reports that are filed with our various bureaus on vital statistics, that there was being made no compilation of morbidity statistics in non-communicable diseases, and that the knowledge to be gained from a compilation of such reports might prove to be of value; so that instead of studying death reports as we are doing today, we may, in the future, study the reports of sickness as it occurs among our population, and thereby gain additional information on public health matters. This would be largely, in a measure, an experiment to see whether it has any value, whether it can be done.

The motion was adopted.

DR. BACHMEYER: The third motion I have to present, which was adopted by the section yesterday and comes before you as a recommendation and for official adoption, is the one following Dr. Faxon's paper, the subject of which was the statistics which a hospital should collect. This is to the effect that the matter of considering, compiling and recommending standard forms and tables for hospital statistics and annual reports be referred to some existing committee or a committee specially to be appointed by the Association. In explanation I may say that our annual reports today contain all kinds of tables none of which are of general value. They may be of value to the individual hospital, but they are of very little value to any group of hospitals or for purposes of comparison. This committee would endeavor to set a standard which we would all follow in compiling our statistics and publishing them in our annual reports.

(The motion was adopted without discussion.)

DR. BACHMEYER: That completes my report.

MR. DANIEL D. TEST: This committee clearly indicated yesterday that they did not want any bouquets, but it seems to me that this is one of the most constructive pieces of work we have had in the Association, and I do not feel willing to let it go by without expressing my appreciation of what they have done, and there are no bouquets in that.

CHAIRMAN BALDWIN: I am sure the committee understands that it has the thanks of the Association. Next in order is the report of the special committee for the

Study of State Subsidy for Hospitals, Mr. Howell Wright, Chairman.

MR. HOWELL WRIGHT: Mr. President, ladies and gentlemen: The other two members of this Committee (Dr. Winford H. Smith and Mr. Daniel D. Test) gave the chairman a free hand in preparing the material for this report. A preliminary report only is possible, however, at this time. We hope to have a complete report available at the end of the year. It will be in four parts:

1. A bibliography of the literature on the subject.
2. A digest of state constitutional provisions, the state laws and the city ordinances on this subject, with a brief statement of how those are enforced and operated in the various political subdivisions.
3. A statement of opinions of hospital officials, hospital trustees, superintendents and other officials, and public officials with respect to principles and policies so far as they relate to the subsidy system.
4. Recommendations.

We hope to have the report printed and distributed to the hospitals. I will not inflict even a preliminary report upon this Convention on such a hot night as this but I will make brief reference to the legislative aspects of the subsidy problem. They are such as to require constant attention of hospital officials in many states. In Pennsylvania at this time the people are considering a constitutional amendment which, if adopted, would mean a complete revolutionizing of the subsidy system in that state. Several of the State Legislatures are confronted with the problem at every session and often have to make decisions without the constructive help of hospital representatives. Except in few instances, the organized efforts of the hospitals to correct faulty legislation and to improve administrative defects have been very weak. The problem as a whole is such great importance as to require the active interest and attention of the American Hospital Association.

The Association, however, is not equipped as it should be to meet this responsibility. I have spoken on this subject before but again want to emphasize the necessity of an active legislative department in the headquarters of the Association. Unless the Association wakes up at an early date and creates such a department, it will continue to be only a minor factor in public health legislation in this country.



CHAIRMAN BALDWIN: The Secretary will explain what we have had in mind.

SECRETARY WARNER: I wish to answer Mr. Wright's statement. When it comes to flaying the Association for what it has not done, particularly on the line legislation, I really think that I could do a better job than he did. He told you a little of the truth, but not all the truth. We have been dead asleep, and the justification that any legislative committee has for inaction, including the one that Mr. Wright was on, is that it is absolutely impossible for committees simply appointed by the Association to do anything worth while. The only way to do any job worth while is to create a service bureau on legislation. This is made almost essential by the development of geographical sections. The great service which the American Hospital Association can perform to geographical sections is legislative information and advice as to legislation. There is now an appeal before the American Hospital Association, to get in now and help forestall vicious legislation that is coming up in that particular state just as sure as the legislature opens. This is not the open staff bill, either, which certainly will appear in many states and you will have to fight it or else pay taxes. The states need the help; the states need state associations to meet those menaces and nothing else will ever meet them but an organization of the hospitals in the various states. But back of that, back of them and supporting them, there must be the united support of the united hospital field. That does not exist today; and before we can handle those menaces in the way that humanity requires that they be handled, we must build that support, and the only way to build it is to make the American Hospital Association in fact what it is in name. This will include a legislative service bureau. All the basic material, that is, the codification of all the laws of all the states affecting hospitals is available at a price. I think we can buy it cheaper than we can make it. It is going to cost in the thousands either way, but that must be had before anybody can do anything. That, then, must be kept up to date, which will mean an item of expense each month. We lack only the amount of money necessary, because I believe the basic data and the right man are available. Then when a menace appears or is imminent in any state, that man from his experience and from that knowledge of what has been done or what has not been done in other states, can map out a program for

that state hospital association which will enable them to meet that menace in the only way that I can yet conceive to be effective.

REV. H. L. FRITSCHER, of Milwaukee: In the state of Wisconsin, we had bills introduced in the legislature twice which we had to fight. I would appreciate it very much if the officers of this Association would in some way give us support, because we expect this pernicious legislation to be brought up again in the legislature. Is there no way in which this Association can go on record or instruct the officers to voice its disapproval of such legislation? I feel, as Dr. Warner, that the geographical units will have to watch out for such vicious legislation, and oppose it.

MR. PLINY O. CLARK: As long as it seems improbable that the trustees will be able to organize and put in operation such a bureau immediately, much as we all would desire it, I move that the report as submitted by Mr. Wright, be accepted as a partial report, a report of progress, and that the committee be continued for another year.

(Motion seconded)

Mr. Clark's motion was unanimously adopted.

CHAIRMAN BALDWIN: Dr. Howland, of the committee on Constitution and Rules, desires to offer an amendment to the Constitution. This is important; it relates to membership.

DR. HOWLAND: The committee on Constitution and Rules presents the following report for action at a later session.

The Trustees of the Association recommend that the Constitution be amended as follows:

Article III Section I—After the first paragraph insert the following:

ACTIVE—Active institutional members shall be institutions having direct responsibility for the care of patients however such institution may be designated.

After the words "application for" in the following paragraph insert the word "active".

After the words "eligible to" in the same paragraph insert the words "active institutional".

After the word "constituent" at the beginning of the next paragraph insert the word "active".

At the end of the second paragraph of this Section insert the following:

ASSOCIATE—Associate institutional members shall be corporations, associations or other organizations existing for the promotion of public health but not having direct responsibility for the care of patients.

Applications for associate institutional membership shall be addressed to the Executive Secretary in writing signed by a duly authorized representative of the corporation or association; they shall be referred to the Membership Committee and the applicant shall become a member upon receiving the approval of a majority of the Membership Committee and the payment of the dues for the first year.

Constituent associate institutional members shall be entitled to appoint as their representative any person or persons eligible to active or associate personal membership or officers of the corporations or organizations without other hospital connections, who shall have all privileges except vote.

At the end of Article III add the following:

Section 4—Established personal membership shall be continued for life on the payment of fifty dollars by active members and twenty-five dollars by associate members with exemption from the payment of dues.

In Article IV—Section 1 of the By-Laws:

Strike out the words "a Committee on Local Arrangements to consist of the President and Executive Secretary ex-officio and such additional persons as he may deem advisable" and also in the second, third and fourth lines, and also the words "and a Committee on Time and Place of Next Meeting, composed of a Trustee, the Executive Secretary and a member at large", in the seventh, eighth and ninth lines; also the words "appointed by the President" in the first and second lines of page 5 (next page).

The Committee endorses and reports the above changes for action by the Association.

John M. Peters

J. B. Howland

A. K. Haywood

SECRETARY WARNER: Perhaps a brief explanation of those changes and the working effect of them, may be

in order. The first changes accomplish the addition of the associate institutional membership, and makes the hospitals which are now the institutional members active institutional members. It defines what an active institutional member shall be, and what an associate institutional member shall be.

The second change is about the life membership. We do not know why, but life membership is not mentioned in the Constitution, although it is in the By-Laws. In some of the numerous reprintings of the Constitution, it is possible that this line may have gotten dropped off; and we are, therefore, re-submitting the original provision.

The third change is the dropping of the local committees and the dropping of the time and place committee. These are made necessary by good business management. No one who wanted to buy a certain horse would go to the man who owned that horse and say, "My family insists upon having that horse; they won't have any other; I have got to buy that horse; now what are the terms?" That is poor business, and that is the position you put your executive secretary in when you say we shall meet next year at this or that place. The hotels of that city know exactly what our requirements are to the square foot, and they know just which hotel in that city fills those requirements and they are waiting for you when you get there.

When the time and place were definitely settled at the convention, then a local committee could be formed at once, but if not settled the appointment of the local committee must be at the discretion of the President.

MR. PLINY O. CLARK: This convention is missing the presence of one of the Trustees of the Association, one who has given liberally of his time, means and influence to the building up of the organization to the enviable position it now occupies. I refer to Mr. Richard P. Borden who is unable to be here because of a serious illness.

I therefore move that the executive secretary be requested to send Mr. Borden a message of sympathy and hope that his recovery will be a rapid one.

(This motion was seconded and unanimously adopted, after which the session adjourned.)

## GENERAL SESSION CONDUCTED BY SECTION ON DIETETICS

September 16, 1921, 10:00 A. M.

Miss Lulu Graves in the Chair

CHAIRMAN GRAVES: Probably all of you know that this is the first meeting of the dietetic section of the American Hospital Association, and we are very glad indeed to be a section of the American Hospital Association. We feel that this is an opportunity for the dietitians and superintendents to exchange ideas and suggestions, and we hope that this is going to be done through this section. The program scheduled for the first speaker this morning is a paper on food preservation by John Phillips Street, of Indianapolis, Indiana. Just a short time ago I received a telegram from Mr. Street saying that he had missed his train, so he is not here for the delivery of this paper, and we will have the paper that is scheduled next on the program, *The Dietitian an Asset to the Hospital*, by Miss Rena Eckman, Chief Dietitian, University Hospital, Ann Arbor, Mich.

To those who have been happily provided with a competent dietitian the title of this paper may seem a humorous one. To dietitians at large it may seem facetious. But to any one who has observed the activities of hospital dietitians over the length and breadth of the land, the question often arises, "What is the dietitian doing for the hospital that an untrained woman cannot do; and what is she not doing for the hospital which would be perfectly in keeping with her training and which would be of great benefit to the hospital?"

I once heard a superintendent of nurses in a large hospital make a few remarks on the subject. They were something like the following: "At first we wondered what to do with her. It seemed as if she might be an asset. But anon we also wondered if she were not also a liability. She seemed to possess knowledge that was a bit disconcerting to the buyer of food products; seemed to know things about food preparation that excited a longing inclination toward certain localities of the hospital and made discontent arise in other parts of it. She seemed to be somewhat like a cat in a strange environment, not very happy within the confines of her borders, inclined to be

alternately frightened, entertained, amused, horrified or dismayed by the routine occurrences, professional, economical and social."

"But," the superintendent continued, "we found that after a certain amount of orientation had taken place, many conditions were so much improved that we could not think of going back to the time when there was no dietitian."

The dietitian finds many fields of usefulness open to her. In school lunch work where she has been sole manager of the food problem, her capability has been fully proved. Equipment, buying, handling of labor and technical supervision of cooked food products are phases of this vocation. Philadelphia, Rochester, Boston New York and many other large cities have efficient school lunch systems. Many corporations, large department stores, banks and manufactories who employ large numbers of men and women have found it profitable to serve not only a noonday lunch but to care for the undernourished employee.

One banking institution in the City of New York operates such a plan. The dietitian of this bank told me that every known form of hospital diet, other than experimental, was represented in the daily output of her kitchen.

Now the evidence seems to show that the dietitian possesses certain capabilities or she would not be employed in organizations who manifestly cannot afford to run a lunch room or cafeteria at a loss. Miss Blanche Geary of the National Board, Y. W. C. A., New York City, recently said to the president of the American Dietetic Association: "Within six months we shall need fifty cafeteria managers. Within a year we shall need fifty more. We will pay these women from \$1,500 to \$3,000 per year, with food maintenance, often with full maintenance. You home economics people who conduct schools of practical arts must train these women for us."

Most organizations make the position of dietitian fairly attractive. We who are interested in having the hospital field covered, realizing what a great need there is for the various branches of dietetics in hospital work, are confronted by the attitude of technical schools and practical arts departments of colleges who have placed themselves on record as advising their students to keep away from hospitals. When interviewed on the subject the answer is, "Hospitals do not do their part in the training of the dietitian who is to specialize in hospital work."



If we analyze the conditions under which dietitians work we will find that a certain standardization is prevalent which applies to duties, hours and freedom of activities.

The application of these principles to the hospital field may be more or less difficult. But the modern trend of hospital management includes much talk of standardization. Hospitals on the accredited list must show that certain activities are present and are carried out with due precision. Accredited schools of nursing adopt certain standards of admission for the young women who would enter training and demand certain qualifications before allowing them to finish the course. Hence, in selecting a dietitian should she not be trained in an accredited school of theoretical and technical preparation? When suitably prepared the nature of the hospital field demands an internship of definite duration in an accredited practice field, before she should become an applicant for a position on the staff.

But let us return to the subject title of the paper. The administrative dietitian will have definite supervision of her department. The equipment there found, represents a vast amount of money. It is no small matter to have an intelligent watchful eye to inspect the operation and care of this machinery. The use and abuse of equipment should be controlled to the great advantage of the hospital. Picture for a fleeting moment what can happen to linen, dishes, silver, plumbing, power machinery, etc., without the application of intelligent principles of economy.

The care and inspection of food from its entrance into the hospital to the arrival at the service table is another tremendous item. Next to salaries, food cost is the largest figure in the budget of an institution. Unpopular food, poor quality either in the raw state or as a result of improper cooking, and unsuitable food preparations mean conspicuous waste. If poor quality food is bought it will be wasted not only in the process of preparation but also on the tables where it is served.

Other institutions than hospitals have found that it pays to care for their employees. The undernourished child in school lags behind his class. A mid-morning lunch is beneficial to his health, and improvement in his studies is not long in following. A little attention to the needs of poor nutrition, or the anemia of convalescence from minor ailments can increase the efficiency of the working force of the hospital far beyond the expense of

providing for the same. That a suitable service room must be available for this purpose goes without saying. A diet laboratory is a work shop and should never be construed to a catering or social center. Supplies may be issued from there but never consumed there.

The question of educational feeding of children within hospital walls demands consideration. A selected menu is only part of the problem. Both sick and convalescent children, yes, even adults, would be materially benefited if someone stood guard over the food presented to them, suggesting, recommending, coaxing, cajoling and sometimes even commanding that food be eaten. I know of one university hospital where an assistant dietitian regularly seats herself at a long table where a number of convalescent children eat their meals. She makes it her business to see that the food is palatable, that the cooked or raw green vegetables are administered in some way to tempt the appetite, and that the soup is at least tasted several times as an education to the palate. Many times when a tray is put before a child he will attack the dessert, the popular dish, the white bread, or the food to which he has been accustomed and leave to wholesale waste the dish of spinach, string beans, or fruit sauce. Young children may not need roughage to stimulate peristalsis. But they do need to be taught to eat a variety of food, especially the iron bearing and anti-scorbutic fruits and vegetables. If training in proper food habits is not begun in childhood, far too many children will continue to swell the ranks of victims of deficiency diseases and subjects of low immunity to infections.

Dr. Dennett, in an address before the American Dietetic Association in 1921, said, "The modern trend in the care of children involves a maximum of dietetics with a minimum of medicine," and cited a record of one hundred cases of serious ailments in which fifty-four out of the whole number were cured solely by dietetics and hygiene. The importance of proper nursing care plus proper feeding is already not only recognized but is being more and more emphasized.

I know a mother who brought her little boy to the hospital with severe osteomyelitis of arms and legs. His little pale peaked face showed plainly a poor nutritive condition. Besides the nursing care he received, the dietitian visited him often and the nurses cooperated with her in forcing milk, fruit, and vegetables in the diet and forbidding absolutely the tea and coffee which he had been

allowed to drink at home. He left the hospital four months later with an educated appetite and an educated mother. She promised the dietitian with pathetic emphasis that she would never allow her six-year old boy to drink coffee and tea again.

You say that it belongs to the business of nursing to administer food to patients. But what better could one do when thirty or more diets need supervision and only five or six nurses are available to serve, carry trays, and attend to all the things that never cease to come up even at meal time. Every little helps. The education of the pupil nurse is at stake as well as the care of the patient. The supervision of the food intake is one of the practical developments of nursing education.

What I am recommending for children has already been carried out in feeding helpless patients, especially typhoids. Many grown-ups are rather proud of their dislikes and tend to humor them rather than to modify them. Patients with finicky appetites should be urged to cooperate with the hospital who is trying to benefit them by giving intelligent but not whimsical attention to the food tray.

What should the institution require of a dietitian along practical lines other than the above? Why should not problems be studied similar to those that are scrutinized by an institution that feeds for profit? The life of a utensil, the amount of repairs necessary with various kinds of equipment, reports of phases of labor, census distribution in relation to cost per capita, allotment, routing, height and suitability of working spaces and surfaces must be thought of in planning new kitchens and in remodeling old ones. Sanitation if ever needed at all in a hospital is a keen necessity along the entire line of food preparation and service.

How much more intelligent demands could be made upon the food service budget if the dietitian could bring evidence of economic balance of menus. To illustrate: combine an expensive meat or vegetable with an inexpensive dessert, and vice versa. Conceal the matter from being too obvious by considering the popularity of the combination.

In reference to the more practical problems always present in the administrative dietetic field, it is opportune to say a few words. During the war we found it most desirable to replace man power in every possible way, by machinery, by condensing organization and by introducing

cafeteria service. As yet we cannot find a surplus of desirable employees available. Most of the labor saving devices will be continued even when stability in labor has become less unusual. The central plant conserves labor and expense. To have a workable central plant is the problem to be considered if it is to be installed.

During the war we improvised and adapted to the last degree and obtained a great measure of success in operating a department with a short labor personnel. Now we must expand a little toward pre-war conditions but not forget the lessons we learned in conservation, and readapt them to the better operation of the plant.

Central dishwashing has been tried with a measure of success. With suitable conveyances, elevators and topographical situations it is practicable. The character of dishes used may need to be modified. Distances should be studied with reference to time, labor and risk of breakage. Sources of contamination may be met with on the way to and from the dishwasher. Elevators may get out of order or traffic may be heavy and interfere with efficiency. The question of sterilization of dishes is more easily met in such a system than when hand power is used as in many different service rooms.

When more than one kitchen is operated many activities such as soup making, ice cream, cooking of fruit, vegetables and certain kinds of meat can be assigned advantageously to one of these kitchens and the products transferred to the others, as we have long since learned to do in transferring bread, rolls, cake, and baked desserts. More intensive study of the center as a qualitative producer will be necessary. An interested chief of the department is able to safeguard results to much better advantage.

While it has long been recognized that broth carries little nourishment we still find it useful for flavor, variety, stimulation, and for conveying liquid food into forced fluid diets. Plain broth or consommé may be made in large quantities, strained and left to jelly in an ice cold refrigerator. A protective covering of fat will seal it and it can be readily kept for a week or more. A more elastic menu can be served when facilities exist for keeping supplies on hand, and when brains and interest are coupled with the desire to work.

Fruit juices for liquid diets may be prepared in the central diet kitchen and dispensed either in bulk or as a bedside order. In our hospital we have various devices for

making this up. In the late summer and fall fruit juices are most easily obtained. During the war we learned to can them as such and wait for the price of sugar to fall. Then they were used or dispensed as needed. Jelly could be made at any time. Fruit juice was ready for pudding or ice cream flavoring, for sherbet or other purposes.

Canned fruit is often made into pies or desserts, which do not require all of the juice. A dietitian I once met in the Middle West had a most clever way of mixing and flavoring collections of fruit juice and concentrating for ice cream sauces. The ice cream was always a delight for the flavor or the dip could be varied in so many ways.

Studies in the care of linen involve laundering and mending. We use paper napkins during the peach and pear season, placing a small package of them on each table when fruit is served in its natural condition. A suggestion in the shape of a conspicuous sign placed at the entrance to the dining room—"Kindly use paper napkins with the fruit. Thank you," and the family respond cordially. The laundry supervisor has been asked to refrain from bleaching each time the linen is washed and give one general bleach at the end of the offending fruit season. This procedure is less destructive to the fabric than bleaching every time stains appear. The stained linen is not a bad reminder to the family and helps them to realize the effect of their own thoughtlessness when fingers covered with fruit juice are wiped upon napkins.

Linen should be inspected for wear each time it is laundered, and promptly mended. Worn tablecloths may be made into tray cloths and napkins. Dish towels should be darned and patched until they become too thin to hold together. Continual war should be waged against the use of dish towels and napkins for cleaning and polishing furniture and utensils. It is hard to believe that any hospital employee is so benighted that he or she would use a soiled guest napkin to wipe a clean plate, but such atrocities have been known to occur and sanitation in respect to methods of kitchen and serving room technic is by no means above reproach.

We require our ward dish washers to carry their soiled dish towels to a certain locality and hang them up to dry before throwing them into the laundry hamper. During the summer this precaution is most necessary. The same procedure is needed for kitchen aprons. Mould and mildew do not enhance the appearance of wearing apparel

or even suggest cleanliness. As we use better methods of housekeeping we attract higher class workers to our force of employees. Wanton carelessness of hospital linen is not by any means confined to a single department.

Kitchen utensils, in my opinion, should be washed in a moderately deep kitchen sink where there is not room enough to pile great numbers of them one upon the other for the purpose of soaking. A great weight of utensils damages those of the smaller sort. The operator in pulling this or that utensil around for this or that reason known only to himself, bends, twists, warps, wrenches off handles and damages even comparatively heavy tin, Russian iron, or agate containers. If the practice of long soaking in a vat of strong soap suds is used, all utensils are devoid of tin plate in a very few washings. A good chef will cooperate in protective therapy applied to his departmental furnishings. But I have had an old experienced man chef calmly assert to me that it did no harm to soak aluminum pudding moulds or other aluminum utensils in strong soap suds and that woman cook books were impracticable for large institutions. My reply to the former is, "Look at the dinges, indentations and small pittings in your aluminum utensils that have been subjected repeatedly to a vat bath of hospital made soft soap." To the latter, "Ask the family at large to compare the taste of institutional food where the number is over two hundred with that of the home product." In the former case how often can you find utensils clean to the touch? If standardized recipes are used, all of the art of the magician is needed to prevent the criticism—"Everything always tastes just the same." In defense of the kitchen I say, "How almost impossible it is to obtain from the commissary department the flavorings, garnishes, and niceties to secure attractiveness to the eye and palate." The spur of commercial aim is lacking in providing institutional dietaries. The buyer does not always realize his responsibility in this part of the institution's problems. Good quality of food must be bought or good results in dietaries cannot be obtained. Employees are prone to work, not for appreciation but to earn their wage with as little trouble as possible and to depart promptly at the end of an eight hour day.

Organized systems of commendation and criticism are valuable aids in maintaining standards of cleanliness and good service, although therein also lie dangers. The high authority who deals out the criticism should realize the



human attributes of even the humblest dishwasher. Often have I seen employees line up en masse, not willing to go off duty until they had heard the verdict rendered by the inspection committee. Their eyes shone with expectancy, hoping to hear "satisfactory"; crestfallen, shrinking demeanor showed how humiliating it was to them if some forgotten corner exposed lurking dirt. And if by toil and sweat they had scrubbed their tables to whiteness and their metal to shining luster and the dignitary did not appear at the expected stated time to make inspection, groans and gestures of disappointment were evidenced with unction. Appreciation is dear to all. As a rule I have found that employees would rather be noticed adversely than ignored.

When food is sent to a ward in carts that are used to serve from, it is highly desirable for these carts to return to the kitchen to be cared for. Food is covered, of course, on its way to and from the ward. Left over food which is in suitable condition can be used. The noise of washing utensils is removed from the ward. The utensils return to the kitchen while the employees are still there and can be suitably put in order for the next meal service. Missing utensils can be checked up and much inconvenience avoided. It is also an economical labor problem, as one man or woman can wash up ten or a dozen carts and save the time of ward employees who are usually hired for this purpose.

Dietitians have met and will continue to meet many kinds of housekeeping problems. In the many different types of institutions which hospitals present it must be expected that they will continue to meet problems which must be worked out on the hospital premises.

The majority of people, trained not too intensively in one direction retain the power of adaptability to new environment. It can be said with a large proportion of truth that adaptability or death has been the rôle of dietitians. That she can exceed the leopard in his power to change his spots has been proven in many instances. We find her combining duties of housekeeper, store keeper, buyer, and general manager with those of her own realm, and we predict that as new fields open up she will not only continue to be an asset to hospitals and cafeterias but also to increasing numbers of food industries.

CHAIRMAN GRAVES: I am sure Miss Eckman will be very glad to answer any questions, or if there is any

discussion of the points she has brought out, we will take a few minutes for that.

MR. PLINY O. CLARK: I wish Miss Eckman had discussed the subject of the central serving kitchen as opposed to the serving kitchens on the floor, a little further.

MISS ECKMAN: Trays may be served from one center when the service room is centrally located or when there is dumb waiter service between the kitchen and the patients' floors. I have known this to be successfully done. But when wards are widely scattered this method is very difficult to carry out satisfactorily.

DR. C. W. MUNGER, Milwaukee, Wis.: I have had a little experience in serving trays in that way in a hospital of somewhat less than 100 beds, a five story building, 3 floors having patients, and we attempted, for a period of a year, to serve all of our trays from the main kitchen, which is on the ground floor. It is connected with the upper floors by a dumbwaiter which gives prompt delivery. I regret to say that we found that by no methods we could arrange could we get the food to the patient in a really palatable condition; we had constant complaints on account of cold food and food which had stood too long. We tried every method we could possibly devise to speed up the service, but the system did not seem to work for us.

We are able, however, to wash all of our dishes in a central dishwasher. The advantages, as I see it, of this process are first, that one can use the type of dishwasher which sterilizes all the dishes, and in that way prevent the spreading of infection as far as dishes are concerned, from patient to patient. The dishes of the patients whom we know to have some transmissible disease, are sterilized on the floor before they go to the main kitchen, but there is still a certain very definite hazard in washing the dishes of supposedly non-infectious cases in the floor diet kitchen and then passing them back to other patients without any effectual sterilization.

I would like also to emphasize the importance of the medical examination of employees. Two experiences with epidemics were enough to teach me a lesson. These epidemics could be traced to kitchen employees, and both were employees of recent acquisition. The epidemics were not very extensive, but were sufficient to cause apprehension, and the precautions necessarily employed seriously upset the hospital routine. We now institute a very careful examination of every employee who comes

in, not only to the kitchen but to any part of the hospital. As soon as a worker is employed, he or she goes directly to an examining room where one of the house staff makes an examination. If, for any reason, he wants to call a staff man, he can do so. A very thorough examination is made, especially as to whether the individual has any active throat or respiratory trouble or venereal disease. If there is not a good vaccination scar, the employee is vaccinated. He also receives a Schick test, and a record of the result is made. Positives who will consent to it are immunized with toxin-antitoxin mixture. This rather new biological product effectually immunizes against diphtheria for a period of years or possibly for life. In case toxin-antitoxin mixture is not used a record of the Schick reaction informs the employer, in case of diphtheria epidemic, as to which persons should receive immunizing doses of antitoxin. This is all done before the employee starts to work. If he balked we would simply let him go and pass on to the next applicant. The system has not thus far caused any resignations. We also administer typhoid vaccine. We also watch employees closely at all times for infections of the hands, and for colds. If there is any coryza or coughing, those so afflicted are put on duty in parts of the hospital where they can work alone and are distant from patients or food. If the condition is serious they are sent off duty altogether. I believe that careful medical examination and supervision of employees is a point demanding attention.

MR. DAVIDSON; of Philadelphia: We have a three story hospital of 135 beds in Philadelphia and we serve all our private rooms from our central serving kitchen without any complaint from the patients regarding cold or unpalatable food, and we are going to rearrange our service to centralize the serving of food.

MISS LULU M. YOUNG, of Nichols Memorial Hospital, Battle Creek, Mich.: Ours is a 100 bed hospital building, three stories and basement. The diet kitchen is in the basement.

We send our trays up to each floor first, set with the silver, dishes and uncooked foods. These are arranged on a two-tier tray receiver in the hall.

The food, hot from the stove, is placed in our Food Conveyor, built on the thermos plan such as is exhibited here, run onto the elevator and taken to the floors where the trays are waiting.

The hot food is dished directly to the trays and is taken immediately to the patient by the hall nurses. It takes an average of eight minutes to serve each floor, of which there are six, three in the main building and three in the annex. The dietitian and two nurses attend to the serving from the food conveyor.

CHAIRMAN GRAVES: How many trays do you serve?

MISS YOUNG: Our average is 75 patients.

DR. JOSEPH B. HOWLAND, Supt. Peter Bent Brigham Hospital, Boston, Mass: The Massachusetts General Hospital has a private ward of 100 beds, catering to people of means. In that hospital, which is an eight story building, all diets are served from the main kitchen in the basement. As soon as the trays are arranged they are put in an electrically heated cart and sent up on an elevator to the proper floor. There is a space for sufficient trays for the patients on that floor, and as soon as the trays are all sent up, the moment they reach the serving room, which is directly opposite the elevator, immediately the heat is connected again so that they are kept hot until the trays are taken out. The trays become heated and it is necessary to shift the dishes from a hot to a cold tray, but the system has a distinct advantage in this, the average nurse, if she is to set up a tray, will not make as attractive a tray as a trained chef or a trained dietitian. You know yourself how the little things the chef does in garnishing trays and dishes make all the difference between their being attractive or unattractive. The food is delivered absolutely hot to the patients and there is rarely a complaint.

CHAIRMAN GRAVES: What do you do with your bread and butter and the cold things?

DR. HOWLAND: They go up separately; only the hot things go on the trays; the cold things are added. The large serving wagon has a rail on top and here outside are put the receptacles for the cold things. I think everybody recognizes that milk is one of the best mediums for the growth of bacteria we have to deal with in the hospital. I believe that where it is possible, milk should be handled, from its reception in the hospital to the time it is delivered into the receptacles to go to each department, by one individual. The hospital with which I am connected, each morning after the milk arrives, before it is handled, the milkman goes to the assistant superintendent's office, the doctor looks in his throat to see if he is coming down with a cold or any signs of a cold,

looks at his hands to see if he has got any septic wound, and if he has either, he is told not to handle the milk, and another employee handles the milk until that man is well. That sounds rather elaborate, but it can be done easily as a routine thing every day, and if it is done, I believe you will save yourself many epidemics which put out of business your doctors and nurses and keep in the hospitals your patients with epidemics of throat sepsis which may prolong their stay. It is a very simple thing and can be done in a hospital, no matter how small, if there is a single resident doctor around.

MR. F. E. CHAPMAN: Your initial examination is of no value at all unless you follow it up and what Dr. Howland says about your milkman should be applied to everybody in your dietary department. Most especially we apply it and have applied it for three years now to every individual in the department every sixty days.

As to the serving unit, it is a question of transportation facilities pure and simple; from the standpoint of economy there isn't any question that the central kitchen is the ideal thing. Heated carts are very fine, but it seems to me that the possibility of abuse of heated carts is very great, and it will absolutely change the character of your food product if it stays in that heated cart too long. With all due respect to Dr. Davidson, I do not believe that you can shoot food up or down an elevator on a tray and not have complaint.

MR. ANTHONY TALL, of Elyria, Ohio: We have a hospital of 175 beds, pavilion type; one about 300 yards from the main hospital, for which we use a Toledo Food Cart. We serve sixty children and the cart is wheeled directly into the dining room. We have found central kitchens and serving rooms preferable. Where food is transported and transferred a number of times, nurses will pick over food, resulting in much waste and allow the food to become cold. The main thing with us is to improve the food service. We serve directly from the food cart to the patients. We endeavor to make the trays attractive by using flowers in the finger bowls and on the trays. We have a garden for growing flowers, and one person is delegated to see that fresh flowers are sent to each floor daily. There are many other reasons that tend to economy by using central serving rooms in place of floor diet kitchens.

MR. JOHN M. SMITH, Supt. of the Hahnemann Hospital, Philadelphia: We have 350 beds, 126 of which are pri-

vate. These 126 beds are in three buildings. The diet kitchen is in the basement of one of these three. In the building in which the diet kitchen is located, the private rooms are on the first and second floors, connected by an elevator; in another building, the private rooms are on the third, fourth and fifth floors; in the third building the private rooms are on the second, third and fourth floors. These buildings are separated by private driveways. We have tunnels connecting them and the elevators. Commencing last April, we established a central diet kitchen in the basement of one building, and we serve all our rooms complete, except ice cream or other frozen desserts, from that kitchen. The trays for a certain floor are made entirely complete, except the frozen desserts, and are put on a suitable truck with rubber tires, hurried onto an elevator through the tunnel and up to the floor. We have succeeded in getting the trays into the patients' rooms at the furthest point in less than five minutes. We have not, since the first week the system was put in, had a single complaint that food was cold, and have had many, many compliments. I think it is entirely a matter of working out a good system, and insisting on its being followed every day. In serving the trays, the dietitian is the absolute boss, and if the nurses are slow on any floors, the dietitian immediately calls the directress or assistant directress and that does not happen again on that floor for a long time.

CHAIRMAN GRAVES: Are there any other points in Miss Eckman's paper that any of you would like to discuss before we take up the next question?

MR. DANIEL D. TEST: The matter of milk is such an important matter—my system is quite different from Dr. Howland's, and I would like him to tell us how that man handles the milk.

DR. HOWLAND: I want to say to start with that the system we have is not by any means perfect, in that we buy pasteurized milk. It is obvious that milk pasteurized at the point where it is produced is not the ideal thing; the pasteurization should be done at the point of distribution and just before distribution, but that is not practical, because I think poor pasteurization is the most dangerous thing anybody can fool with, you are likely to be incubating instead of pasteurizing, unless you do it in a scientific way. The pasteurized milk comes to the hospital and the milkman empties the cans into a large mixing vat, which is porcelain lined, a regular dairy



vat with a large spigot to draw off from at the bottom, and from there each ward has milk sent to it three times a day. The milkman knows from a schedule given him each day that Ward A is to have six quarts in the morning, ten quarts at noon and six at night, etc. He selects suitable sterile cans and draws the milk off. They are labeled cans. He does not put his hands to it, does not dip it, but draws it off and puts on the cover immediately. The morning milk is sent with the other supplies to the different wards, and the noon and night milk is put in the refrigerator and at the proper time is sent to the wards.

DR. MUNGER: How do you check the milk as to contents?

DR. HOWLAND: Once a week as to butter fat and as to bacterial count.

DR. MUNGER: Do you ever try checking the bacterial count at the source? I mean the central supply closet, and then carry that through and see the possibility of what actual contamination there is before it gets to the patient?

DR. HOWLAND: No.

MR. ASA BACON: I would like to ask the doctor a question. He has told us about the milk up to the time it gets to the ward in the can holding four or five quarts who handles the milk then?

DR. HOWLAND: The nurses. Our object in sending the milk three times a day instead of sending a large supply to last twenty-four hours is that if you send a twenty-four hour supply it will frequently be gone in twelve hours, so we think it is more practical to send it three times a day. The amount we allow for the ward comes nearer to serving twenty-four hours, but after it is put into the ward refrigerator, the nurses handle it for their individual needs.

DR. ROBT. J. WILSON, of New York City: I think that what Dr. Howland has just said is a most essential thing to avoid minor infections, and perhaps in some cases major infections, but I believe that at every meeting of this kind where opportunity offers, somebody in the Association—and I take it upon myself this time—should urge the examination of all food handlers as far as possible, to find out whether or not they are carriers; that is, there are certain things that can be done always—typhoid, of course, is the thing you are most afraid of amongst carriers; you probably think a typhoid carrier does not often get into the food handling province; everybody has heard

of Sloan Maternity, I have at this moment under my jurisdiction two cooks who are chronic typhoid carriers from Sloan Maternity, one hospital in one town. There are other things you can do so also test them for Wasserman; certainly every cook should be tested for Wasserman, and certainly in the city of New York no food handler can work in a public kitchen without being tested, and I think that is much more important, in a way, than what Dr. Howland called attention to a moment ago, although it seems to me that Dr. Howland's precaution of examining this milk handler every morning might very well apply to the entire dietetic department.

MR. ANTHONY TALL: Milk for patients is purchased in one-half pint bottles; for the kitchen in ten gallon pasteurized cans. When the milk is brought to the hospital it is taken care of by the dietitian and her assistants. Outside of bottle is thoroughly washed and placed in the refrigerator. The milk is sent to the patients in one-half pint containers. We take a sample of the milk each week and send it to the pathological department for examination. By this method two persons only handle the milk; the person who puts it in the bottle and the nurse who removes it to the glass. One hospital in which I was Superintendent we had a complete pasteurizing plant. The milk was placed in one quart sterilized bottles. The weekly routine examinations were taken by our pathologist and the monthly examination by the City officials. This is the most satisfactory way to handle milk. It is more expensive than the other, but you save your institution many infections which are traceable to the uncleanly method of handling milk.

CHAIRMAN GRAVES: We are not going to be able to get through all these questions that have come in. I am going to take time, however, to present one to you that will probably take a very short time to answer, and it comes to me almost every week of the year and I should like to have the opinion of a number of you who have large or small dietary departments. "What should be the proper title and status of the dietitian?" I think that question comes to me at least fifty times a year, and I would like to hear somebody answer it. Is there anyone here who will volunteer? Dr. MacEachern, will you answer that question?

DR. MACEACHERN: I would say director of dietetics, and she should have complete charge of everything concerning the food in connection with the hospital, which

would include the kind of food purchased, the quality, the preparation and the service. I do not know whether that is possible; I am just suggesting it.

CHAIRMAN GRAVES: Would you suggest a title?

DR. MACEACHERN: Director of Dietetics, inasmuch as she directs the management, the instruction and the scientific side.

CHAIRMAN GRAVES: Would anyone like to add a word to this in just a moment? We have several women in this capacity who are being called all kinds of names, some of them not very complimentary sometimes, and ranging through the scope of dietitian, director of dietary department, supervisor of dietary department, house director—some are called assistant superintendents, etc. It is not so much a question of what she should be called as of what she should do, and perhaps her status.

The session then adjourned.

## GENERAL SESSION

September 16, 1921, 11:00 A. M.

President Baldwin in the Chair

PRESIDENT BALDWIN: We will proceed with the program. The first paper is Cooperative Purchasing by Hospitals, by Mr. Guy J. Clark, Purchasing Agent of the Cleveland Hospital Council, Cleveland, Ohio.

MR. CLARK: The Cleveland Hospital Council, an organization of twenty hospitals, is incorporated under the laws of the State of Ohio for the following purposes: "To promote the efficiency of, and cooperation between, the various interested hospitals, to the end of better meeting the needs of the hospitals of the community and to doing all other things that are incidental to the proper conduct of the affairs of the Council and its constituent members."

Pursuant to this, the purchasing department was started on June 10, 1918, its purpose being to buy supplies and establish standardization in hospital supplies.

During the first six months the purchasing department was in operation, there was very little purchasing done for the hospitals. The department has had a considerable increase in the amount of purchases since that time, and has gradually added some of the children's institutions to the list for which it purchases.

It has been a matter of education. We feel that confidence has been established, as the hospitals are usually satisfied with the products which are purchased for them. Many savings have been made for the individual hospitals, which tends to give them greater confidence in the purchasing department, particularly when the savings are noticeable to the hospital itself.

At times it seems that a purchasing department for charitable institutions, or even business institutions, is very slow in the placing of orders. We will readily admit that except on contracts it is not possible to buy supplies through a central purchasing department on requisition and get the order placed as quickly as if the institution itself places the order. We do contend, however, that there is a great deal of difference between the placing of an order and the buying of the same order. In fact, there is so much difference in the operation that there is no resemblance. The hospitals appreciate the service which a purchasing department renders quite as much as they do the saving of money which is made by quantity and cooperative buying. The department renders a very definite service to the hospitals by sending bulletins on price changes and market conditions, and also in the exchange of supplies between hospitals, possible because of the department's knowledge of which hospital has a certain kind of supply on hand at the time when another hospital may be short of it.

There is available a fund of \$10,000 which enables us to discount all contract bills and a great many other bills for purchases which we make. This establishes for us a good credit with the merchants from whom we buy our supplies. By taking cash discounts, it has encouraged some of the hospitals to take advantage of such discounts and practically every hospital in the organization is now doing so.

Most salesmen prefer to sell direct to the person who actually uses the supplies and show preference to dealing with heads of departments rather than superintendents. Naturally, they were not keen for a central purchasing department and at times have expressed themselves as opposed to it. What opposition we had at the beginning has gradually disappeared because we have proven to the hospitals that we are buying quality merchandise at the best price, not poor quality in order to get price. It is our aim to have the hospitals feel that their satisfaction is very definitely our obligation and that we are

both working for the same cause. The only difference between a purchasing department and a selling organization is that one is trying to save money and the other is trying to make money. In Cleveland, we are not trying to run the institutions on less money but are endeavoring to get the greatest amount of value from every dollar spent.

With volume of purchases, we are usually able to get better protection on price agreements than individual hospitals could get. It is firmly believed that central purchasing eliminates a lot of substitution, as the vendors of merchandise are more careful about substitution when there is a chance of their losing the business of twenty institutions than when they might lose the business of one institution. A very definite saving is shown to the smaller hospitals, as we are usually able to get the same price on supplies for the small hospitals as for the large ones. It is reasonably safe to assume that the receiving clerk in a hospital is more likely to complain on supplies received that are purchased by the central purchasing department than if they are purchased by an individual in the institution. It is my firm belief that if a central purchasing department did not save any money on quantity purchases and standardization, that the institutions would still be justified in maintaining such a department from the standpoint of service and the fact that fewer supplies are ordered when it is necessary to purchase on requisition. Buying on requisition tends to keep purchases down to a minimum and is a saving which, although it cannot be proven, is nevertheless there.

Through the cooperation and the hard work of the purchasing committee and sub-committees and the hospital representatives, the purchasing department has been able to standardize quite a few of its purchases. The outstanding standardizations are as follows:

The standard specifications on canned fruits and vegetables, a part of which specifications all members of the American Hospital Association have seen, as copies have been sent out in the form of a bulletin by Dr. A. R. Warner. We have gone further than a specification on fruits and have had fairly good success with our specifications on vegetables. We have found, however, that it is much more difficult to get the jobbers to follow a specification on vegetables than on fruits, as the canners of vegetables are not as well organized as the fruit canners. The canners of vegetables are widely separated and in

many different states and varying climates, while the fruit canners are very much confined to California. However, the time is coming when every can will be marked plainly as to its contents.

The meat specifications which were recently issued as a bulletin of the American Hospital Association have worked out as nearly one hundred per cent as could reasonably be expected from any standard specification. We rarely have a complaint from the hospitals on their meat and usually the complaints are a misunderstanding as to how the meat is to be cut rather than in the matter of quality. The suppliers of our meat are particularly keen for business at this time and are working on very narrow margins. A saving of at least 10 per cent can be shown over what the hospitals themselves would pay for meat of a like quality. The meat purchases alone for the members of the Cleveland Hospital Council amount to approximately \$160,000 a year, and the quantity is sufficient to demand close prices.

Recently the government, at the request of the Hospital Council and the Western Reserve School of Pharmacy, amended Article 74, Regulation No. 61, of the National Prohibition Regulations, by adding the following:

Where a number of institutions, such as scientific universities, colleges of learning, laboratories engaged in scientific research, hospitals, or sanatoriums, within the same Internal Revenue collection district, are entitled to withdraw alcohol tax-free, and are affiliated or associated together for educational or scientific purposes, any one of such institutions may use alcohol withdrawn under its permit free of tax in compounding alcoholic medicinal preparations unfit for beverage use to be furnished to the other associated or affiliated institutions without profit. In no case, however, may medicinal compounds be manufactured for this purpose until application has been made to the Commissioner of Internal Revenue and his permission obtained to do so.

No preparation so made and furnished may be used in any manner by the institution to which it is furnished except as provided in the first paragraph of this article.

In addition to the regular monthly report on Form 1451, the institutions withdrawing the alcohol for the purposes indicated herein shall submit to the Collector of Internal Revenue each month a statement showing the products prepared, and the quantity of such products distributed to each associated institution.

This will allow the School of Pharmacy of the Western Reserve University of Cleveland to manufacture medicinal preparations for the hospitals which are members of the Cleveland Hospital Council and associated with the West-



ern Reserve University through the Cleveland Hospital Council. This arrangement will save the institutions a considerable amount of money and will give the students in the university the necessary amount of work in their course of pharmacy, and, in the future, the School of Pharmacy hopes to supply the smaller hospitals with intern pharmacists. This will enable the hospitals to secure a uniform quality of medicinal preparations. The work of compounding the preparations will be supervised at all times by the teachers in the school.

It is hoped that in the near future we will get started on the making of gauze dressings and pads in one central point for all of the hospitals, the pads and dressings to be made of standard sizes already agreed upon by the institutions themselves. This will mean that all hospitals will be using pads and dressings made in the same way, of the same size and, as far as possible, from gauze of the same quality. The work will be done by volunteer help, and will be handled in the same way that the Red Cross handled the making of pads and dressings during the war.

Credit for the success which we have attained in Cleveland by this method of purchasing should be given to the fine spirit of cooperation which exists among the hospitals of Cleveland, to the constant efforts of the purchasing committee, and lastly, to the personnel of the department.

**PRESIDENT BALDWIN:** Owing to the fact that Mr. Clark is not feeling well, Mr. Chapman is going to take charge of the rest of the meeting, and Mr. Chapman will be very glad to answer any questions or to entertain any discussion.

**MR. CHAPMAN:** I have worked with Mr. Clark on this standardization work and on the entire purchasing program of the Cleveland Hospital Council, and while I am not in any way as competent as Mr. Clark to answer questions, I will do my best.

**SECRETARY WARNER:** Mr. Chapman, there is one question I am particularly interested in, and that is how your standardized dressings are working out? When I used to be in Cleveland everybody had to have just such a dressing for just such a purpose, and if there were four staff men, they all had to have them different. How is it working out?

**MR. CHAPMAN:** The operation of a central gauze room is dependent entirely on the personnel you have to manage it. So far as standard dressings are concerned, I

would like to report the snappiest committee work I have ever seen on that committee; we passed the problem right back to the schools of nursing in the city and said "You standardize your own dressings." We had a report of that committee within 72 hours after the request was made to them. We cut it down from 117 different sizes of dressings to 18 sizes of dressings for all the institutions in town. Please do not misunderstand me. I do not say that a maternity group will not use something that a general group not handling maternity does use, but the general run of dressings is 18, which includes manufactured binders; that is, which includes the padded binder. The reason that the thing has not been started is that Mrs. Burke, who had charge of our Red Cross center during the war, has been in Europe and by reason of the magnitude of the job we had before us and by reason of Mrs. Burke's peculiar qualifications as an organizer, we felt that it was very desirable that we await her return so that she, in turn, could start her team captains and get her organization going. You understand we are going to handle this with volunteer labor throughout, with the exception of one paid distributor. Now the economy in it is the exceedingly largely increased number of reclamations in hospitals that reclaim their gauze. We have estimated that Lakeside alone will save over \$4,000 a year in labor charge to say nothing of taking the bugaboo of reworked dressings out of their own institution. We will report progress now and report a finished job next year.

DR. WILSON: I am very much interested in this central purchasing idea, and would like to know this; first, do you furnish to each member of the Council the standard specifications under which the supplies are purchased? If you do furnish such standard specifications, and the hospital receiving the supplies, we will say meat for instance—and I want to have it perishable supplies—the hospital receiving the supplies does not think it is up to the standard specifications, who rejects that supply and what does the hospital do pending the arbitration between the Council and the consumer?

MR. CHAPMAN: Number one; a copy of the specifications is furnished to all institutions. Number two; the ultimate responsibility is in the administrator of the hospital; if it is rejected, that is all there is to it, the hospital council has to make the adjustment.

DR. WILSON: Does it work that way with all.

MR. CHAPMAN: I do not think there is any question about it. You will have isolated instances, and bear in mind that one of the greatest cogs in the wheels of progress is the personnel of the individual hospitals, the dietist, and so on and so on. They do not like it at first, but after they get sold to the idea and after they see the service that the hospital council purchasing bureau can render, they would not have it the other way. Miss Deaver, our dietitian, fussed about this thing for six months, but I do not think there is a more ardent supporter of it today than she is, and when you convince her, you have gone some.

DR. WILSON: How much time does it take between the receipt of the original requisition by the purchasing department until the delivery of the goods?

MR. CHAPMAN: Standard stuff is bought on schedule, and this system is predicted upon anticipation of wants; you must anticipate your wants, or you cannot get by. If your requisition comes down on Monday morning, in all probability your supplies will be delivered by Wednesday, provided they are bought in town. If it comes down on Wednesday morning, your supplies will not be delivered until the following Wednesday.

DR. WALTER H. CONLEY, Medical Superintendent of Metropolitan Hospital, New York City: What about replacement rejection?

MR. CHAPMAN: Dr. Conley, I want to get this idea across, that so far as the delivery of commodities is concerned, it is a contract between the hospital and the vendor of merchandise. To expedite matters, our complaints may go through the hospital council; as a matter of fact, they do go through, because Mr. Clark has set up a service that permits it, but you will get exactly the same type of service you would get from the vendor of merchandise if you were dealing with him direct, and get better service.

DR. CONLEY: We have a service bureau in the city of New York that purchases everything for all departments, but we have constant trouble with replacements; we have to keep substituting all the time, particularly fresh fruits and vegetables, those are the things we have the most trouble with. We do not know what to do, cannot get the replacements; the vendor is so slow in making the replacements that some days we have to substitute something entirely different. Do you have the same trouble?

MR. CHAPMAN: No, we do not. Do you Miss Hogle?

MISS HOGLE, Superintendent of Huron Road Hospital, Cleveland: No.

SECRETARY WARNER: I think I had the worst possible of it. One day the trustees met and voted that the purchases for Lakeside Hospital should thenceforth be made by the purchasing department of the Cleveland Hospital Council, and instantly I had to go from the old basis of buying all supplies through my own agents to buying them all through the Cleveland Hospital Council. Of course the purchasing bureau of that Council had been working for some time; they had been buying some of our supplies; they were organized to give service. The change was accomplished without one hitch, except that some of the department heads who had been doing some of the buying did not like it, but as far as the hospital was concerned, it was perfectly satisfactory from the first day.

MR. GUY J. CLARK: I feel a little stronger now, and the first thing I want to do is ask a question myself. You saw both of the bulletins sent out by Dr. Warner, one on canned foods and the other on meats; how many hospitals showed their purchasing agents those specifications? Is the specification all right or is there some objection to it. How about specifications of your own? How many are using specifications of your own, that you draw up yourself?

PRESIDENT BALDWIN: Six.

MR. GUY CLARK: We take the attitude that the hospital is right at all times. Once in awhile some of the people in our office will say, as Mr. Chapman said, "If the strawberries are good enough for you, they are good enough for somebody else," but that should never happen, I do not want it to happen, but it will once in awhile. As far as exchanges are concerned, we have enough buying power that if this particular fellow does not want to exchange that at the hour we say he should, he is liable to be cut off the list, and about two hours after he is cut off, he comes around with tears in his eyes and wants the business awfully bad, and the service you get from that fellow for about two months is beyond question.

DR. WILSON: In asking the question, I was actuated entirely by the selfish motive of going back home and saying that the purchasing department of the city of New

York might profit by going out to Cleveland and doing a little intensive studying.

MR. GUY CLARK: I told you why we have enough purchasing power to demand service, and in the next place we do nothing else except buy and we are on the job all the time. My personal belief—now I don't want any superintendent here to take offense at which I am going to say, but my personal belief is that the average hospital, from a purchasing standpoint, is the loosest kind of purchasing method I know anything about. I think there are more salesmen that prey on the hospitals than on any other set of institutions or any other kind of business that there is, and I think they get away with it to a greater extent, too. I think that as a rule the reason for that is that most of the heads of departments buy or are supposed to buy, they do not, they place orders, and there isn't anybody who can buy and place orders at the same time.

MR. PLINY O. CLARK: I for one, greatly appreciate this discussion, and I think each of the superintendents who do not have specifications and who do not have the advantage of such a splendid purchasing department as has been organized in Cleveland, is grateful for the standards and pioneer work which is being done. I agree with Mr. Clark that the average superintendent is no good as a buyer, and when we can, in our large cities, take advantage of such an organization as you have perfected, it seems to me that we have solved one of the problems which is worrying us more persistently than any other one thing in our hospitals, and it can be, as has been shown, done in a fairly scientific manner. I hope we may still have the advantages of these bulletins which the Secretary has been sending out, because they will in time be used.

MR. GUY CLARK: I like to be encouraged by such remarks as that, Mr. Clark. We are very glad to give the American Hospital Association the advantage of anything we may get together in Cleveland. We want to see them used generally all over the country, and I am really surprised and disappointed to see that there are not more superintendents in this room who are using that standard specification. The meat specification has not been out very long and I can appreciate that you have not had time to put any of those views to work, but on the canned goods specification, the biggest humbug in this country today is canned goods, and if you could only realize that when you are buying a label, you do not know any more

what you are buying than when you are buying a pig in a bag, the canned goods are in a can and you can not see through it. Labels do not mean anything. The California Cannery Association puts up their standard canned goods on a standard specification, it makes no difference whether it is Libby's pack or whether it is Griffin or Skelly's pack or whose it is. The syrup is exactly the same that goes in a can of fruit, it contains 40 degree syrup, all mixed in the same manner, so many pounds of sugar go into that can, there must be a certain number of peaches in a can, of a certain degree of ripeness and they must have no blemishes on them, and so on down, so that your canned goods specification, by your purchasing agent or dietitian or whoever buys them, can be brought down to a scientific basis; it is a standard of their own before the fruit is packed, and I venture to say that 99 per cent of the institutions here are using California packed canned fruits. You cannot get uniform canned goods anywhere else, so there is no reason why you should say to any salesman that you want his label. Here is what you get back from the salesman; "It's our label," and 90 per cent of those salesmen don't know what you are talking about when you say 40 or 50 degree syrup; he is educated to talk his label and that is as far as he ever goes, to find out that that label is of a certain color and has certain things you find on there, and outside of that he does not know what is in the can. The hospital is entitled to know. You can get that information, Dr. Warner will supply it to you, and it is not any big effort to use it.

MR. DANIEL D. TEST: May I ask whether, in Cleveland, you have arrangements whereby hospitals outside of Cleveland can take advantage of your specifications, even though they might not order goods through you? After you have answered that question, I would like to say a word about it.

MR. GUY CLARK: No, we have not. The specification that we have has been given to the American Hospital Association. You can use it, of course, and as we get other specifications together, they will be sent. I want to answer you on the subject of the New York Bureau. One of the reasons I am here today is that Dr. Warner told me, when I agreed to come, that I could say whatever I wanted to, and I am going to be real frank about the New York Bureau. We are a member and so was Lakeside Hospital when Dr. Warner was superintendent.



The reason more hospitals do not get value out of the New York Bureau is because you do not use it; your buyer does not take advantage of the New York Bureau. They can do a lot of things for him that will save him work if he will let them. When we want something we cannot locate in our market, we write to New York and let them buy it, and your buyer can do the same. The standard specifications they have are good enough for any hospital. Their regular towels are as good as anybody's, and they are made by the Star & Crescent Company, of Philadelphia, makers of regular bath towels. The reason the New York Bureau is not a success to some hospitals is because the hospitals who belong to it do not use it; that is what would happen in Cleveland if they were not on the job all the time.

MR. DANIEL TEST: I accept your criticism, but you cannot expect any hospital to buy from the Bureau when they can buy things cheaper at home. For instance, we buy 95 per cent alcohol cheaper in Philadelphia, without freight, than we could ever get it in New York without freight.

MR. GUY CLARK: I agree to that; we buy it ourselves cheaper, but there's a whole lot of things you cannot buy cheaper, and on one or two items in a year you would save your fee and could save a whole lot more if you would look into it. Your buyers are sometimes prejudiced against the New York Bureau. There's lots of times when your buyer wants to buy something somewhere else, even though the New York Bureau may have a contract on it. He wants to buy from a particular individual.

DR. WILSON: Might I ask Mr. Clark this question, if it is a fair one; since the Council has been operating this purchasing department, has there been a comparative cost accounting running under the old purchasing department, for instance, Lakeside, by Council, to find out whether or not there has been a very material saving to the institution?

MR. GUY CLARK: No, there has not.

DR. WILSON: There is not any question about its having been a saving?

MR. GUY CLARK: Absolutely not. We can prove plenty of savings all right, but being a community fund, we are not trying to save money, we are not trying to run the hospitals of Cleveland cheap, but we do want to get a dollar's worth of value for every dollar we spend. Every dollar we save means that the patient in the hospital or

the hospitals themselves can spend one more dollar for something they need.

DR. WALTER H. CONLEY, of New York: A Central Purchasing System has been installed in about 50 Chapters of Greek letter fraternities at the Universities of Wisconsin, Michigan, and Illinois; also, a simple workable system of accounts has been installed in these same Chapter, and supervised. It has been found that from 15 to 20 per cent has been saved by this Central Purchasing System on account of buying in large units for distribution among the different chapter houses, therefore, obtaining the benefits of quantity prices.

MR. GUY CLARK: We have never made the claim in Cleveland that we save on the whole over 10 per cent. Let me tell you about some of the things you can do with the central purchasing department. The superintendents in the hospitals are naturally not able to figure on market conditions; they are busy all the time; their aim is to make the patient comfortable and to get the work done in the best manner that they can. The secondary consideration of a hospital superintendent, unless they have a purchasing agent in their own institution, is their supplies, and it naturally has to be; they have so many other duties to perform. We can watch market conditions; we can get protection on contracts. A lot of you superintendents went over to some of these booths during this convention and noticed gauze way up and were surprised; you did not know why gauze should go up, you thought everything was going to go down, and cotton was up; it was a surprise to you because you had not the time to follow market conditions. It was not any surprise to us because we follow the cotton market and the stock market. Every day each man in our office looks at the stock market; every day, if he is buying meat, he must know what the market conditions on meats are, where beef was today; he can tell you what hogs and what sheep were; he knows the basic price of all the articles he is going to place orders for today, and so on all the way through. I insist upon them knowing what the market conditions are from our local newspapers every day.

MR. PLINY O. CLARK: I would just like to correct an impression I seem to have made, and that was that I would criticise the New York Purchasing Bureau. My experience with it as a non-resident member was very satisfactory, and I have no complaint whatever to offer; I think it rendered a splendid service. We cannot all of

us have purchasing departments. Mr. Clark, what practical suggestions have you for us in isolated places as to the way in which we may keep up with the market? One man here is an expert, I think, on purchasing for his own hospital. Perhaps you have some particular suggestion how the rest of us may become as expert as he is.

MR. GUY CLARK: I think that a man who is a hospital superintendent and an expert in buying is an individual all to himself, because I think that a man who is hospital superintendent and still a high grade buyer is a natural buyer. I should think that some day the American Hospital Association will have to set up some sort of a bulletin system to keep their members in touch with the market conditions; if not that, then they should have as far as possible, standard specifications which should be used. How many superintendents here know what a bedside table with a white porcelain enamelled iron top is compared to what a bedside table with a steel porcelain enamelled top is when they look at it in a catalogue? Do you know how to measure it when it comes to finding out if you have the thickness compared to what you bought? Is there anybody here who buys that way on those things? They may on the initial order because the architect told them to. Do they measure it when it comes in?

PRESIDENT BALDWIN: Owing to the time, we will have to close this session so far as the discussion of Mr. Clark's paper is concerned, and I would like to take up two or three of the items scheduled for this afternoon, in order to save time. First, is the report of the committee on constitution and rules which will be read by the Secretary.

SECRETARY WARNER: This committee report was presented and read according to the constitution last night, and according to the constitution comes up now for final action.

MR. PLINY O. CLARK: I move the adoption of the report.

The motion was seconded and carried.

PRESIDENT BALDWIN: Next is the report of the committee on resolutions.

Dr. Bachmeyer, Chairman. The committee has had few resolutions submitted to it, in fact none except one last evening, when it was suggested that this committee

present a resolution directed at vicious legislation in the various states. We therefore offer this resolution:

RESOLVED: That the American Hospital Association expresses unqualified disapproval of all legislation which in any way interferes with the continuation and development of organized medical staffs or the classification of hospitals as charitable institutions.

On motion, the foregoing resolution was adopted.

DR. BACHMEYER: The other resolution I have is one of appreciation, as follows:

RESOLVED: That the American Hospital Association recognize the educational and service value of the exposition of commercial products as now organized and conducted and expresses its appreciation for the effort made and the courtesy extended to its members by the various firms in furnishing information and instruction, relative to the development of equipment, appliances and material used in our institutions.

On motion, the foregoing resolution was adopted, after which the meeting adjourned.

## GENERAL SESSION

September 16, 1921—2 P.M.

CHAIRMAN BALDWIN: We will first have the report of the Treasurer and the Auditing Committee.

### Statement of Cash Receipts and Disbursements

For the Year Ending August 31, 1921

Chicago, September 10, 1921.

To the Board of Trustees,

The American Hospital Association,

Chicago.

Dear Sirs: We have audited the accounts of The American Hospital Association for the year ending August 31, 1921, and submit herewith a Statement of Cash Receipts and Disbursements for the year, on which we comment as follows:

The Cash on hand at August 31, 1921, as shown in Exhibit A, amounting to \$5,978.80, included the following:

Cash in Bank—

Hospital Flooring Fund.....\$ 871.06

General Fund..... 5,057.74

————— \$5,928.80

Petty Cash Fund.....	50.00
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Total.....	\$5,978.80
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The Balance in Bank was verified by reconciliation with the balance as certified to us by the depository.

The Petty Cash Fund was verified by count.

At August 31, 1921 the Life Membership Fund amounted to \$1,504.64, represented by the following assets:

Liberty Loan Bonds (Par Value)

Third 4¼ %.....	\$450.00
Fourth 4¼ %.....	100.00
	<hr/>
	\$550.00

Great Northern Railway Company 7%

Bonds (Par Value \$600) at cost.....	573.48
Cash in Bank.....	381.16

Total.....	\$1,504.64
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We have received a certificate from the Union Trust Company stating that they hold these bonds for safekeeping, and verifying the balance on deposit.

Yours faithfully,

ARTHUR YOUNG & Co.

## EXHIBIT A

### *Statement of Cash Receipts and Disbursements*

*For the Year Ending August 31, 1921*

Balance, September 1, 1920.....	\$ 4,269.12
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#### *Receipts:*

Institutional Membership Fees.	\$ 7,399.90
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Personal Membership Fees—

Active .....	\$4,814.10
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Associate .....	462.00
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Life .....	605.00
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	5,881.10

Commercial Exhibits—

1920 Exhibit.....	\$ 5,015.20
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1921 Exhibit.....	11,990.00
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	17,005.20

Interest on Bank Balances....	55.63
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Sales of Transactions.....	28.50
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Reimbursement for Expenditures made on account of—

Dental Survey....	\$ 2,541.23
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Social Service Survey .....	1,581.19
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Philadelphia Survey .....	605.49	
Detroit Survey....	516.92	
American Conference on Hospital Service .....	193.13	
	<hr/>	5,437.96
Reimbursement from Exhibitors at 1920 Convention for expenditures on their behalf..	108.40	
Sundry Refunds.....	498.36	
Donation for Hospital Flooring Fund .....	1,000.00	
Donation for Hospital Forms Fund .....	500.00	
Miscellaneous .....	96.61	
	<hr/>	38,011.66
		<hr/>
		\$42,280.78

*Disbursements:*

Office of the President—General	\$	50.47	
Office of the Treasurer—General		25.00	
Board of Trustees—			
General .....	\$	5.60	
Traveling .....		541.08	
		<hr/>	546.68
Office of the Secretary—			
Salaries .....	\$12,905.00		
Equipment .....	229.13		
Supplies .....	1,035.54		
Traveling .....	432.29		
Petty Cash.....	882.46		
Bulletins .....	285.60		
General .....	2,522.95		
	<hr/>		18,292.97
Convention Expense—			
General .....	\$ 2,513.44		
Commercial Exhibits .....	2,208.90		
	<hr/>		4,722.34
Service Bureaus—			
Dispensaries and Community Relations .....	\$ 1,353.81		



Hospital Social		
Work .....	409.62	
Library and Service		
Bureau .....	60.50	
	<hr/>	1,823.93
Surveys—		
Social Service.....	\$ 2,469.14	
Dental .....	2,491.23	
Detroit .....	501.92	
Montreal .....	300.00	
	<hr/>	5,762.29
Out-Patient Committee.....	156.20	
Transactions .....	1,978.05	
Flooring Study.....	128.94	
Hospital Forms.....	1,220.46	
Expenditures on behalf of Glen		
Falls Hospital.....	183.70	
Donation to American Confer-		
ence on Hospital Service Lib-		
rary .....	558.35	
Sundry Refunds .....	107.50	
Miscellaneous .....	20.10	
Transferred to Life Membership		
Fund .....	725.00	
	<hr/>	36,301.98
Balance, August 31, 1921:		
Cash in Bank, Union Trust		
Company, Chicago.....	\$ 5,928.80	
Petty Cash Fund on Hand....	50.00	
	<hr/>	\$ 5,978.80

CHAIRMAN BALDWIN: What is your pleasure with regard to the report?

DR. MOULDER: I move that the report be received.  
(Motion adopted.)

CHAIRMAN BALDWIN: Next is the report of the Nominating Committee, Miss Keith.

## REPORT OF NOMINATING COMMITTEE

For President Elect—

Mr. Asa S. Bacon, Supt., Presbyterian Hospital,  
Chicago, Ill.

For 1st Vice-President—

A. C. Bachmeyer, M. D., Supt. Cincinnati General  
Hospital, Cincinnati, Ohio.

For 2nd Vice-President—

Harold W. Hersey, M. D., Supt. New Haven Hospital,  
New Haven, Conn.

For 3rd Vice-President—

Miss Harriet Hartry, Supt. St. Barnabas Hospital,  
Minneapolis, Minn.

Trustees:

Mr. Richard P. Borden, Trustee, Union Hospital, Fall  
River, Mass.

Mr. Daniel D. Test, Supt. Pennsylvania Hospital,  
Philadelphia, Pa.

Treasurer—

It is suggested by your Committee that the present Treasurer, if confirmed as President Elect, should be re-elected as Treasurer for the ensuing year. The President Elect will not assume the duties and responsibilities of President until after the 1922 Convention. It is the belief of this Committee that in the election of a Treasurer a candidate approved by the Board of Trustees should be selected by the Convention. If Mr. Bacon is re-elected as Treasurer, the Board of Trustees will have ample opportunity during the coming year to arrange for a transfer of the books and funds of the Association to a Treasurer who may be recommended to the Convention next year. Attention is also called to the fact that the Board of Trustees have power to appoint an Acting Treasurer at any time Mr. Bacon or the Board may desire to make the transfer.

Respectfully submitted

W. L. Babcock

Mary L. Keith

Frank E. Chapman

MR. PLINY CLARK: I move that the report of the Nominating Committee be received and that the Secretary be instructed to cast the unanimous ballot of the Association for the officers as named.

Mr. Clark's motion was unanimously adopted, the ballot cast in accordance therewith and the nominees declared duly elected.

CHAIRMAN BALDWIN: Before proceeding further, I would like to state that the paper listed in the program for this afternoon to be presented by Mr. Bradley is in my hands. Mr. Bradley was ill and asked to be excused so that he could get the 1:40 train, and I recommend that this paper be read by title and published. I have read the paper. It is a very valuable paper, and with your consent I have turned it over to the Secretary for publi-

cation, if there is no objection. Published M. H. Dec. 509. This concludes the program. I have the honor to present your next president, Dr. George O'Hanlan.

President George O'Hanlan takes the chair.

CHAIRMAN O'HANLAN: Ladies and gentlemen of the American Hospital Association: I thank you for myself and I take the liberty of doing so in behalf of my associates, for the honor you have conferred upon us. With your assistance and cooperation, I assure you we will do our utmost to make the coming year as successful as those of the past. I think you know all the persons who have just been elected to office, but I am going to ask them to stand so that you will know them when you see them.

(The newly elected officers stood as requested and were received with applause.)

CHAIRMAN O'HANLAN: The Constitution requires that the committees shall be appointed immediately. I therefore, ask the following if they will be kind enough to serve on the following committees:

#### COMMITTEES 1921-1922

##### Constitution and Rules:

Mr. Richard P. Borden, Chairman, Union Hospital, Fall River, Mass.

Mr. A. O. Fonkalerud, Supt. St. Luke's Hospital, Fargo, North Dakota.

Miss Mary E. Surbray, Supt. John C. Proctor Hospital, Peoria, Ill.

##### Legislative:

Christopher E. Parnall, M. D., Chairman, Supt. University Hospital, Ann Arbor, Mich.

Mr. Paul H. Fesler, Supt. State University Hospital, Oklahoma City, Okla.

Mr. F. O. Bates, Supt. Roper Hospital, Charleston, S. C.

##### Nomination:

D. L. Richardson, M. D., Chairman, Supt. City Hospital, Providence, R. I.

Mr. Chas. F. Diehl, Supt. Hospital for Joint Diseases, New York, N. Y.

Miss Margaret Rogers, Supt. Jewish Hospital, St. Louis, Mo.

##### Membership:

Walter H. Conley, M. D., Chairman, Supt. Metropolitan Hospital, New York, N. Y.

Miss Charlotte Jane Garrison, Supt. Sunny Crest Sanatorium, Dubuque, Ia.

Mr. C. J. Cummings, Supt. Tacoma General Hospital, Tacoma, Wash.

Out-patient Work:

A. K. Haywood, M. D., Supt. Montreal General Hospital, Montreal, P. Q.

Alec N. Thomson, M.D., Director, Department of Medical Activities, American Social Hygiene Association, New York, N. Y.

Mr. John E. Ransom, Chairman, Supt. Michael Reese Dispensary, Chicago, Ill.

CHAIRMAN O'HANLAN: The Secretary will communicate with these members. Is there any special business to come before the Association?

A MEMBER: Is the special committee on Forms to be continued?

CHAIRMAN O'HANLAN: All the special committees will kindly continue in office until discharged.

The Convention then adjourned.

## INSTITUTIONAL MEMBERSHIP OF THE AMERICAN HOSPITAL ASSOCIATION

### Active

\*Indicates registration of voting delegates at the 1921 Conference.

#### ALABAMA

\*Moody Hospital, Dothan, Miss Ida S. Inscor, R.N., superintendent.

#### ARKANSAS

\*St. John's Hospital, Fort Smith, Mr. J. R. MacLeod, manager.

#### CALIFORNIA

Samuel Merritt Hospital, Oakland, Mr. H. S. Hudd, superintendent.

Methodist Hospital of Southern California, Los Angeles, Miss Ruth Hartzell, R.N., superintendent.

St. Luke's Hospital, San Francisco, Dr. Wm. R. Dorr, superintendent.

\*Santa Barbara Cottage Hospital, Santa Barbara, Miss Florence C. Johnson, R.N., superintendent.

Scotia Hospital, Scotia, Drs. E. L. and C. C. Cottrell, physicians in charge.

South San Francisco Hospital, South San Francisco, Miss M. Belli, superintendent.

University of California Medical School and Hospitals, San Francisco, Dr. W. E. Musgrave, superintendent.

Florence M. Ward Sanatorium, San Francisco, Miss Irene M. Ferguson, superintendent.

#### COLORADO

Park Avenue Hospital, Denver, Mr. H. Lamborn, superintendent.

\*Presbyterian Hospital of Colorado, Denver, Mr. Pliny O. Clark, superintendent.

University Hospital, Boulder, Miss Martha M. Russell, superintendent.

#### CONNECTICUT

Bristol Hospital, Bristol, Miss Anna M. Goodhall, R.N., superintendent.

Englewood Hospital, Bridgeport, Mrs. K. A. Budds, superintendent.

\*Grace Hospital, New Haven, Miss J. Alison Hunter, R.N., superintendent.

\*Greenwich Hospital, Greenwich, Dr. S. B. Ragsdale, superintendent.

Lawrence and Memorial Associated Hospital, New London, Miss K. M. Prindiville, R. N., superintendent.

St. Mary's Hospital, Waterbury, Mother Superior in charge.

#### DELAWARE

Homeopathic Hospital, Wilmington, Miss M. Louise Pugh, R.N., superintendent.

Milford Emergency Hospital, Milford, Miss Delia M. Battles, R.N., superintendent.

#### FLORIDA

\*Miami City Hospital, Miami, Miss A. Royce, superintendent.

#### GEORGIA

City Hospital, Columbus, Miss N. W. Tew, superintendent.

Macon Hospital, Macon, Mr. L. C. Brown, superintendent.

University Hospital, Augusta, Dr. Carlisle S. Lentz, superintendent.

\*Wesley Memorial Hospital, Atlanta, Mr. Walker White, superintendent.

#### IDAHO

\*St. Luke's Hospital and Training School, Ltd., Boise, Miss Emily Pine, superintendent.

#### ILLINOIS

\*Brokaw Hospital, Normal, Miss L. J. Justis, R. N., superintendent.

Julia F. Burnham Hospital, Champaign, Miss Maud M. Northwood, superintendent.

\*Central Free Dispensary, Chicago, Mrs. Gertrude Howe Button, superintendent.

Englewood Hospital, Chicago, Dr. E. T. Olsen, superintendent.

\*\*Evangelical Deaconess Hospital, Chicago, Rev. H. J. Bauernfeind, superintendent.

Greater General Evangelical Deaconess Hospital, Chicago, Rev. F. Weber, superintendent.

Hahnemann Hospital, Chicago, Mrs. V. A. Horner, superintendent.

Jarman Memorial Hospital, Tuscola, Miss Florence R. Schrader, superintendent.

Mercy Hospital, Chicago, Sister Mary Rita, superintendent.

\*Michael Reese Dispensary, Chicago, Mr. John E. Ransom, superintendent.



- \*Michael Reese Hospital, Chicago, Dr. Herman Smith, superintendent.
- \*\*\*Norwegian American Hospital, Chicago, Miss Alma C. Olsen, superintendent.
- \*Olney Sanitarium, Olney, Miss Katharina Weber, superintendent.
- Passavant Memorial Hospital, Chicago, Miss Charlotte Christian, superintendent.
- Passavant Memorial Hospital, Jacksonville, Miss Ida B. Venner, R.N., superintendent.
- \*Presbyterian Hospital, Chicago, Mr. Asa S. Bacon, superintendent.
- \*John C. Proctor Hospital, Peoria, Miss Mary E. Surbray, R.N., superintendent.
- Provident Hospital & Training School, Chicago, Miss Evelyn M. Kimmell, superintendent.
- \*Rockford Hospital, Rockford, Mr. S. G. Davidson, superintendent.
- St. Luke's Hospital, Chicago, Mr. Charles A. Wardell, superintendent.
- \*Sherman Hospital, Elgin, Miss C. Irene Oberg, superintendent.
- Silver Cross Hospital, Joliet, Miss Marie C. Petersen, superintendent.
- South Chicago Hospital, Chicago, Miss Gertrude A. Briggs, R.N., superintendent.
- Swedish-American Hospital, Rockford, Miss Elsa Rudolph, superintendent.
- \*Mary Thompson Hospital, Chicago, Dr. W. L. Kacin, superintendent.
- Washington Park Hospital, Chicago, Dr. C. O. Young, superintendent.
- West Suburban Hospital Association, Oak Park, Mr. E. J. Hockaday, superintendent.

#### INDIANA

- Elkhart General Hospital, Elkhart, Miss Mary E. MacDonald, R. N. superintendent.
- \*\*Robert W. Long Hospital, Indianapolis, Mr. Robert E. Neff, administrator.
- Muncie Home Hospital, Muncie, Miss Bernetha M. Smith, R. N., superintendent.
- \*Protestant Deaconess Hospital, Evansville, Sister Carolina Braun, superintendent.
- St. Antonio Hospital, Gary, Miss Sheila Farrell, R.N., superintendent.

\*Walker Hospital, Evansville, Drs. Walker and Welborn, owners.

#### IOWA

Des Moines General Hospital, Des Moines, Dr. F. J. Trenery, superintendent.

\*\*Finley Hospital, Dubuque, Miss N. Adele Northrop, R.N., superintendent.

W. G. Graham Hospital, Keokuk, Miss Mary C. Jackson, R.N., superintendent.

\*\*Henry and Catherine L. Hand Hospital, Shenandoah, Miss Margaret S. MacDonald, R.N., superintendent.

Iowa Methodist Hospital, Des Moines, Dr. C. C. Hurin, superintendent.

\*St. Luke's Hospital, Davenport, Miss Martha Baker, R.N., superintendent.

\*\*Washington County Hospital, Washington, Miss Elizabeth Finlay, superintendent.

#### KANSAS

Arkansas City Hospital, Arkansas City, Dr. R. C. Young, superintendent.

Brinkley-Jones Hospital, Inc., Milford, Dr. J. R. Brinkley, chief surgeon.

Halstead Hospital, Halstead, Mr. L. P. Krehbiel, superintendent.

Hatcher Hospital, Wellington, Dr. A. R. Hatcher, president and superintendent.

Hutchinson Methodist Hospital, Hutchinson, Mrs. Charlotte Brigge, R. N., superintendent.

\*\*Mercy Hospital, Fort Scott, Mother Superior in charge.

\*Wichita Hospital, Wichita, Mr. Samuel G. Ascher, superintendent.

#### KENTUCKY

\*\*\*Louisville City Hospital, Louisville, Dr. Henry E. Tuley, superintendent.

\*Norton Memorial Infirmary, Louisville, Miss Alice M. Gags, R. N., superintendent.

#### LOUISIANA

\*Charity Hospital, New Orleans, Dr. W. W. Leake, superintendent.

North Louisiana Sanitarium, Shreveport, Dr. Louis Abramson, superintendent.

Presbyterian Hospital, New Orleans, Miss Hildegard Oertel, superintendent.

Shreveport Charity Hospital, Shreveport, Dr. W. P. Morrill, superintendent.

\*Touro Infirmary, New Orleans, Dr. John D. Spellman, superintendent.

#### MAINE

\*Eastern Maine General Hospital, Bangor, Dr. George H. Stone, superintendent.

Presque Isle General Hospital, Presque Isle, Miss Margaret B. Cowan, R.N., superintendent.

#### MARYLAND

Church Home & Infirmary, Baltimore, Miss Jane E. Nash, superintendent.

Franklin Square Hospital, Baltimore, Dr. Newton I. Parr, superintendent.

\*Hebrew Hospital, Baltimore, Miss Ada R. Rosenthal, R.N., superintendent.

Hospital for the Women of Maryland, Baltimore, Miss Stella W. Sampson, superintendent.

\*Johns Hopkins Hospital, Baltimore, Dr. Winford H. Smith, superintendent.

Maryland General Hospital, Baltimore, Dr. George C. Peck, general superintendent.

\*Union Memorial Hospital, Baltimore, Miss Roberta L. Ball, R.N., superintendent.

#### MASSACHUSETTS

Athol Memorial Hospital, Athol, Mrs. Sarah D. Kendall, superintendent.

\*Beth Israel Hospital, Boston, Dr. Boris E. Greenberg, superintendent.

Boston Dispensary and Hospital for Children, Boston, Mr. Frank E. Wing, director.

\*Peter Bent Brigham Hospital, Boston 17, Dr. Joseph B. Howland, superintendent.

Bristol County Tuberculosis Hospital, Attleboro, Dr. Adam S. MacKnight, superintendent.

Brockton Hospital, Brockton, Dr. F. M. Hollister, superintendent.

Cambridge Hospital, Cambridge, Miss Josephine E. Thurlow, superintendent.

Charles Choate Memorial Hospital, Woburn, Miss Edith F. Bennett, R.N., superintendent.

Faulkner Hospital, Boston, Miss Ruth G. Clark, superintendent.

Franklin County Public Hospital, Greenfield, Miss Annie S. Barclay, R.N., superintendent.

Henry Heywood Memorial Hospital, Gardner, Miss Marietta D. Barnaby, R.N., superintendent.

- \*Collis P. Huntington Memorial Hospital, Boston, Miss Anna L. Gibson, R.N., superintendent.
- Anna Jaques Hospital, Newburyport, Miss Violet L. Kirk, superintendent.
- Malden Hospital, Malden, Miss Rachael McEwen, superintendent.
- Massachusetts Charitable Eye & Ear Infirmary, Boston, Dr. F. A. Washburn, superintendent.
- Memorial Hospital, Worcester, Miss Lucia L. Jaquith, R.N., superintendent.
- New England Baptist Hospital, Boston, Miss Emma A. Anderson, R.N., superintendent.
- \*New England Deaconess Hospital, Boston, Miss Adeliza A. Betts, superintendent.
- St. Luke's Hospital, New Bedford, Miss Georgia M. Nevins, superintendent.
- Springfield Hospital, Springfield, Mr. W. C. Lyon, superintendent.
- \*Union Hospital, Fall River, Miss Jessie M. Cann, superintendent.
- Vincent Memorial Hospital, Boston, Miss Jean C. Fraser, superintendent.
- Wesson Maternity Hospital, Springfield, Miss Winifred H. Brooks, R.N., superintendent.
- \*Winchester Hospital, Winchester, Miss Bessie L. Norton, superintendent.
- Worcester Hahnemann Hospital, Worcester, Miss Suzanne M. Freeman, R.N., superintendent.

#### MICHIGAN .

- \*\*Battle Creek Sanitarium, Battle Creek, Dr. J. H. Kellogg, superintendent.
- \*Beyer Memorial Hospital, Ypsilanti, Miss Lettie E. Day, superintendent.
- \*Blodgett Memorial Hospital, Grand Rapids, Dr. C. W. Munger, superintendent.
- Bronson Methodist Hospital, Kalamazoo, Mrs. E. G. Wildermuth, R.N., superintendent.
- Children's Free Hospital, Detroit, Miss Margaret A. Rogers, superintendent.
- Detroit Eye, Ear, Nose & Throat Hospital, Detroit, Dr. B. R. Shurly, chief executive.
- \*W. A. Foote Memorial Hospital, Jackson, Miss L. Winifred Seckinger, superintendent.
- \*Grace Hospital, Detroit, Dr. W. L. Babcock, superintendent.

- \*Hackley Hospital, Muskegon, Miss Grace D. McElderry, R.N., superintendent.
- Harbor Beach Hospital, Harbor Beach, Dr. F. B. Van Nuys, superintendent.
- \*Harper Hospital, Detroit, Dr. Stewart Hamilton, superintendent.
- \*Highland Park General Hospital, Highland Park, Dr. Willard L. Quennell, superintendent.
- \*Hurley Hospital, Flint, Miss Anna M. Schill, R.N., superintendent.
- Mercy Hospital, Grayling, Mother Superior in charge.
- \*Nichols Memorial Hospital, Battle Creek, Miss Emily Greenwood, superintendent.
- \*\*\*Receiving Hospital, Detroit, Dr. T. K. Gruber, superintendent.
- Saginaw General Hospital, Saginaw, Miss Lenna Matthews, superintendent.
- Saginaw Woman's Hospital, Saginaw, Miss Lydia Thompson, R.N., superintendent.
- \*\*\*University Hospital, Ann Arbor, Dr. C. G. Parnall, superintendent.
- Westerlin Hospital, Iron Mountain, Dr. Wm. J. Anderson, superintendent.
- Woman's Hospital, Detroit, Miss Carrie L. Eggert, superintendent.

#### MINNESOTA

- Asbury Hospital, Minneapolis, Mrs. Sarah H. Knight, superintendent.
- City and County Hospital, St. Paul, Dr. Arthur B. Ancker, superintendent.
- \*Deaconess Hospital, Minneapolis, Sister Marie Folkvard, superintendent.
- Fair Oaks Lodge Sanatorium, Wadena, Dr. George McL. Waldie, superintendent.
- Lake Julia Sanatorium, Puposky, Mr. R. L. Laney, superintendent.
- Mayo Clinic, Rochester, Mr. H. J. Harwick, business manager.
- Mineral Springs Sanatorium, Cannon Falls, Dr. Ernest Strader, superintendent.
- \*St. Luke's Hospital, Duluth, Dr. A. J. McRae, superintendent.
- St. Mary's Hospital, Rochester, Mother Superior in charge.
- \*Swedish Hospital, Minneapolis, Mr. Wm. Mills, superintendent.

Western Minnesota Hospital, Graceville, Miss Anna M. Emge, R.N., superintendent.

\*Winona General Hospital, Winona, Miss Catharine H. Allison, R.N., superintendent.

#### MISSOURI

\*Barnes Hospital, St. Louis, Dr. L. H. Burlingham, superintendent.

\*Christian Church Hospital, Kansas City, Dr. Rush E. Castelaw, superintendent.

\*Jewish Hospital, St. Louis, Miss Margaret Rogers, superintendent.

Levering Hospital, Hannibal, Miss Julia Cherny, R.N., superintendent.

\*\*\*Missouri Baptist Sanitarium, St. Louis, Dr. B. A. Wilkes, superintendent.

Research Hospital, Kansas City, Mr. Fred L. Wooddell, superintendent.

\*St. Louis Maternity Hospital, St. Louis, Miss Isabelle M. Baumhoff, superintendent.

\*St. Luke's Hospital, St. Louis, Miss Frances Chappell, superintendent.

\*Springfield Hospital, Springfield, Miss Vida R. Nevison, superintendent.

Wheatley Provident Hospital, Kansas City, Dr. J. Edward Perry, superintendent.

#### MONTANA

Murray Hospital, Butte, Dr. T. J. Murray, physician in charge.

St. Ann's Hospital, Anaconda, Mother Superior in charge.

#### NEBRASKA

Fremont Hospital, Fremont, Mrs. Marie L. White, superintendent.

\*\*\*Nebraska Methodist Episcopal Hospital, Omaha, Miss Blanche M. Fuller, superintendent.

\*Swedish Mission Hospital, Omaha, Rev. Albin N. Osterholm, superintendent.

#### NEW HAMPSHIRE

Elliot Hospital, Manchester, Miss Helen Caverly, superintendent.

Mary Hitchcock Memorial Hospital, Hanover, Miss Ida Frances Shepard, R.N., superintendent.

Memorial Hospital, North Conway, Miss Grace B. Beattie, superintendent.

Nashua Memorial Hospital, Nashua, Miss Martha A. Wallace, superintendent.



#### NEW JERSEY

- Nathan & Miriam Barnert Memorial Hospital, Paterson, Mr. David Schwab, superintendent.
- \*Burlington County Hospital, Mount Holly, Miss Elizabeth W. Ancker, superintendent.
- Dover General Hospital, Dover, Miss Elizabeth Miller, superintendent.
- \*Hackensack Hospital, Hackensack, Miss Mary J. Stone, superintendent.
- Middlesex General Hospital, New Brunswick, Miss R. N. Clement, R.N., superintendent.
- \*Monmouth Memorial Hospital, Lang Branch, Mrs. Martha M. Scott, R.N., superintendent.
- Muhlenberg Hospital, Plainfield, Miss Marie Louis, R.N., superintendent.
- Newark Beth Israel Hospital, Newark, Mr. Joseph Kar-rakis, superintendent.
- Passaic General Hospital, Passaic, Miss Margaret A. Wal-lace, superintendent.
- Presbyterian Hospital, Newark, Miss A. C. Murray, R.N., superintendent.
- Somerset Hospital, Somerville, Miss J. B. Hamilton, R.N., superintendent.

#### NEW YORK

- Auburn City Hospital, Auburn, Miss Arvilla E. Evering-ham, superintendent.
- Mary Imogene Bassett Hospital, Cooperstown, Dr. Nelson Gapen, superintendent.
- \*Bellevue Hospital, New York City, Dr. Geo. D. O'Hanlon, physician in charge.
- \*Beth Israel Hospital, New York City, Mr. Louis J. Frank, superintendent.
- \*Binghampton City Hospital, Binghampton, Mr. Jerome F. Peck, superintendent.
- Bradford Street Hospital, Brooklyn, Miss Margaret Lacey, chief nurse.
- Broad Street Hospital, Oneida, Miss Jessie Broadhurst, R.N., superintendent.
- \*\*Brooklyn Hospital, Brooklyn, Dr. Willis G. Nealley, superintendent.
- Central Neurological Hospital, Welfare Island, Mr. C. B. Cosgrove, superintendent.
- City Hospital, Welfare Island, Dr. Charles B. Bacon, physician in charge.
- \*Coney Island Hospital, Brooklyn, Dr. Adam Eberle, medical superintendent.

- Cumberland Street Hospital, Brooklyn, Dr. Wm. F. Jacobs, physician in charge.
- Flower Hospital, New York City, Mr. Louis C. Trimble, superintendent.
- Fordham Hospital, New York City, Miss Hannah Malmgren in charge.
- General Hospital of Saranac Lake, Saranac Lake, Miss Emily Denton, superintendent.
- Glens Falls Hospital, Glens Falls, Miss Florence M. V. Lutts, superintendent.
- Gouverneur Hospital, New York City, Miss Jessie A. Stowers in charge.
- \*Greenpoint Hospital, Brooklyn, Dr. Raymond G. Laub, superintendent.
- Hahnemann Hospital, New York City, Dr. Wiley E. Woodbury, director.
- Harlem Hospital, New York City, Mr. C. D. O'Neil in charge.
- \*Highland Hospital, Rochester, Dr. George B. Landers, superintendent.
- \*Hospital & Dispensary for Deformities and Joint Diseases, New York City, Mr. Chas. F. Diehl, superintendent.
- Huntington Hospital, Huntington, Miss Bessie M. Upham, R.N., superintendent.
- Ithaca City Hospital, Ithaca, Mrs. Genevieve M. Clifford, superintendent.
- \*Jamestown General Hospital, Jamestown, Miss Marie Robertson, R.N., superintendent.
- Kings County Hospital, Brooklyn, Dr. Mortimer D. Jones, physician in charge.
- Kingston Avenue Hospital, Brooklyn, Dr. W. T. Cannon, physician in charge.
- \*Knickerbocker Hospital, New York City, Miss Lucy M. Moore, R.N., superintendent.
- Lincoln Hospital & Home, New York City, Dr. Frederick W. Gwyer, superintendent.
- Nathan Littauer Hospital, Gloversville, Miss Emily F. Merwin, superintendent.
- Lutheran Hospital, Brooklyn, Miss Augusta E. Abel, R.N., superintendent.
- Manhattan Maternity & Dispensary, New York City, Miss Emily E. Porter, superintendent.
- \*Memorial Hospital for Treatment of Cancer & Allied Diseases, New York City, Mr. George F. Holmes, superintendent.

- \*Metropolitan Hospital, Welfare Island, Dr. Walter H. Conley, medical superintendent.
- Metropolitan Life Insurance Co. Sanatorium, Mt. McGregor, Dr. Horace J. Howk, physician in charge.
- Montefiore Home & Hospital for Chronic Diseases, New York City, Mr. M. D. Goodman, superintendent.
- Mt. Sinai Hospital, New York City, Dr. S. S. Goldwater, director.
- Municipal Sanatorium for Tuberculosis, Otisville, Orange County, Dr. Donald D. Campbell, physician in charge.
- Neponsit Hospital, Neponsit, L. I., Miss Josephine T. Brass in charge.
- New York City Children's Hospital, Randall's Island, Dr. James F. Vavasour, physician in charge.
- New York Nursery & Child's Hospital, New York City, Mrs. F. W. Kinsey, superintendent.
- New York Society for the Relief of Ruptured and Crippled, New York City, Mr. Joseph D. Flick, superintendent.
- \*\*Norwegian Lutheran Deaconess Home & Hospital, Brooklyn, Rev. C. O. Pedersen, superintendent.
- \*Olean General Hospital, Olean, Mrs. Ethel H. Bates, superintendent.
- Park Avenue Hospital, Rochester, Miss Mary E. Morris, superintendent.
- \*\*Willard Parker Hospital, New York City, Dr. E. Giddings, physician in charge.
- Presbyterian Hospital, New York City, Dr. C. H. Young, superintendent.
- Queensboro Hospital, Jamaica, L. I., Dr. F. S. Westmoreland, physician in charge.
- Reconstruction Hospital, New York City, Mr. Robert Stuart, superintendent.
- Riverside Hospital, New York City, Dr. T. F. Joyce, physician in charge.
- \*Rochester General Hospital, Rochester, Miss Mary L. Keith, superintendent.
- \*Rochester Homeopathic Hospital, Rochester, Miss Maude L. Johnston, superintendent.
- St. Francis Hospital, Port Jervis, Mother Superior in charge.
- \*St. Luke's Home & Hospital, Utica, Mr. I. W. J. McClain, superintendent.
- Sea View Hospital, Staten Island, Dr. Geza Kremer, physician in charge.

- Society of the New York Hospital, New York City, Dr. Thomas Howell, superintendent.
- Soldiers' and Sailors' Memorial Hospital, Penn Yan, Mrs. Ella M. Gibson, superintendent.
- \*Staten Island Hospital, Tompkinsville, Dr. Chas. W. Goodwin, superintendent.
- Frederick Ferris Thompson Hospital, Canandaigua, Miss Elsie K. Kraemer, R.N., superintendent.
- \*Woman's Hospital in the State of New York, New York City, Mr. James U. Norris, superintendent.

#### NORTH CAROLINA

- Clarence Barker Memorial Hospital, Biltmore, Miss Mary P. Laxton, R.N., superintendent.
- \*City Memorial Hospital, Winston-Salem, Dr. T. C. Redfern, superintendent.
- Edgecombe General Hospital, Tarboro, Miss Ethel L. Kelleher, superintendent.
- St. Agnes Hospital, Raleigh, Dr. Jessie A. Duncan, superintendent.
- \*Watts Hospital, West Durham, Dr. J. Warren Knepp, superintendent.

#### NORTH DAKOTA

- \*St. Luke's Hospital, Fargo, Dr. A. O. Fonkalsrud, superintendent.

#### OHIO

- \*Alliance City Hospital, Alliance, Miss Charlotte A. Frye, R.N., superintendent.
- Ashtabula General Hospital, Ashtabula, Mr. B. P. Creelman, superintendent.
- Bethesda Hospital, Zanesville, Miss Lillian L. Allen, R. N., superintendent.
- Brown Memorial Hospital, Conneaut, Miss Jessie J. Hubbard, superintendent.
- Cherrington Hospital, Logan, Miss Eva Crutcher, superintendent.
- \*\*\*Christ Hospital, Cincinnati, Miss Alice P. Thatcher, superintendent.
- Cincinnati Sanitarium, Cincinnati, Dr. F. W. Langdon, medical director.
- \*City Hospital of Akron, Akron, Mr. H. G. Yearick, superintendent.
- \*City Hospital, Bellaire, Miss Mary R. Osborne, superintendent.
- \*Cleveland Homeopathic Hospital, Cleveland, Miss Alma C. Hogle, superintendent.

- \*\*Cleveland Hospital Council, Cleveland, Mr. Howell Wright, executive secretary.
- \*Deaconess Hospital, Cincinnati, Rev. A. G. Lohman, superintendent.
- \*\*Episcopal Hospital for Children, Mr. Auburn, Cincinnati, Miss Harriet Southworth, superintendent.
- Findlay Home & Hospital, Findlay, Miss Mary L. Margerum, superintendent.
- Flower Deaconess Home & Hospital, Toledo, Miss Anna K. Volger, superintendent.
- Good Samaritan Hospital, Cincinnati, Mother Superior in charge.
- Good Samaritan Hospital, Sandusky, Miss Cora A. Kromer, R.N., superintendent.
- \*Good Samaritan Hospital, Zanesville, Mother Superior in charge.
- \*Grace Hospital, Cleveland, Miss Alice C. Graham, R.N., superintendent.
- Holzer Hospital, Gallipolis, Dr. Chas. E. Holzer, owner.
- \*Jewish Hospital, Cincinnati, Mr. Louis C. Levy, superintendent.
- Lake County Hospital Association, Painesville, Mrs. Grace Bond, R.N., superintendent.
- \*\*Lakeside Hospital, Cleveland, Dr. R. H. Bishop, director.
- Lima Hospital Society, Lima, Miss Martha Lambert, superintendent.
- Mansfield General Hospital, Mansfield, Mr. H. R. Taubken, superintendent.
- Martins Ferry Hospital, Martins Ferry, Miss Anna F. Obrist, superintendent.
- Mary Day Nursery & Children's Hospital, Akron, Mr. Arthur O. Bauss, superintendent.
- Massillon Hospital Association, Massillon, Miss Delna I. Hathaway, superintendent.
- \*\*Maternity & Children's Hospital, Toledo, Miss Mary E. Yager, superintendent.
- \*Maternity Hospital, Cleveland, Miss Calvina MacDonald, superintendent.
- Memorial Hospital, Fremont, Miss Daisy C. Kingston, R.N., superintendent.
- \*Memorial Hospital, Piqua, Miss Dessa H. Shaw, R.N., superintendent.
- \*Mercy Hospital, Hamilton, Mother Superior, in charge.
- \*\*Mercy Hospital, Toledo, Mother Superior in charge.
- \*Mt. Sinai Hospital, Cleveland, Mr. F. E. Chapman, superintendent.

Rainbow Hospital for Crippled & Convalescent Children,  
South Euclid, Miss Mary B. Wilson, superintendent.  
Robinwood Hospital, Toledo, Dr. E. B. Gillette, super-  
intendent.

St. Ann's Hospital, Cleveland, Sister M. Geraldine in  
charge.

\*\*\*St. Elizabeth's Hospital, Youngstown, Mother Superior  
in charge.

\*\*\*St. John's Hospital, Cleveland, Mother Superior in  
charge.

\*\*St. Luke's Hospital, Cleveland, Mr. C. B. Hildreth, super-  
intendent.

\*\*St. Vincent Charity Hospital, Cleveland, Mother Superior  
in charge.

Toledo Hospital, Toledo, Mr. P. W. Behrens, superin-  
tendent.

\*Warren City Hospital, Warren, Miss Elizabeth Williams,  
R.N., superintendent.

\*\*Women's Hospital, Cleveland, Miss B. M. Truesdell,  
R. N., superintendent.

Youngstown Hospital Association, Youngstown, Mr. B. W.  
Stewart, superintendent.

#### OKLAHOMA

Morningside Hospital, Tulsa, Mrs. D. I. Browne, super-  
intendent.

Tulsa Hospital, Tulsa, Miss Audrey Abbott, superin-  
tendent.

#### OREGON

\*Good Samaritan Hospital, Portland, Miss Emily L. Love-  
ridge, superintendent.

#### PENNSYLVANIA

Abington Hospital, Abington, Miss M. F. Martin, R. N.,  
superintendent.

\*Allegheny General Hospital, Pittsburgh, Dr. G. Walter  
Zulauf, superintendent.

Beaver Valley General Hospital, New Brighton, Miss  
Clara B. Groscost, superintendent.

J. C. Blair Memorial Hospital, Huntingdon, Miss P.  
Schneider, R.N., superintendent.

Bon Air Sanatorium, Bells Camp, Dr. H. R. Edwards,  
superintendent.

Braddock General Hospital, Braddock, Miss Margaret W.  
Woodside, superintendent.

\*Chester Hospital, Chester, Dr. John A. Drew, superin-  
tendent.



- Children's Homeopathic Hospital of Philadelphia, Philadelphia, Miss Anna L. Schulze, superintendent.
- \*Children's Hospital of Philadelphia, Philadelphia, Miss Susan C. Francis, superintendent.
- \*Clearfield Hospital, Clearfield, Miss Mary A. Rothrock, R.N., superintendent.
- \*Coatesville Hospital, Coatesville, Miss Anna K. Essig, R.N., superintendent.
- \*Conemaugh Valley Memorial Hospital, Johnstown, Dr. Wm. T. Bailey, superintendent.
- Corry Hospital, Corry, Miss Faith A. Collins, superintendent.
- Cottage State Hospital, Philipsburg, Miss Fannie A. Daugherty, R.N., superintendent.
- \*Easton Hospital, Easton, Miss Susan V. Sheaffer, R.N., superintendent.
- Eye & Ear Hospital of Pittsburgh, Pittsburgh, Miss May M. Maloney, superintendent.
- Garretson Hospital of Temple University, Philadelphia, Miss Anna M. Lynch, superintendent.
- Germantown Dispensary and Hospital, Philadelphia, Mr. Chas. A. Gill, superintendent.
- Good Samaritan Hospital, Lebanon, Miss Ida Nudell, R.N., superintendent.
- \*Hahnemann Hospital, Philadelphia, Mr. John M. Smith, superintendent.
- Hahnemann Hospital, Scranton, Mr. F. C. Hilker, superintendent.
- Hamot Hospital, Erie, Mr. George W. Wilson, superintendent.
- Homeopathic Medical & Surgical Hospital, Reading, Miss Lucie K. Wright, superintendent.
- Hospital of the Protestant Episcopal Church in Philadelphia, Philadelphia, Mr. E. F. Leiper, superintendent.
- Hospital of the Woman's Medical College, Philadelphia, Dr. Ellen C. Potter, superintendent.
- Jefferson Hospital, Philadelphia, Dr. Henry K. Mohler, medical director.
- \*Jewish Hospital Association of Philadelphia, Philadelphia, Dr. Simon Tannenbaum, superintendent.
- Kensington Hospital for Women, Philadelphia, Miss Florence C. Beck, R.N., superintendent.
- Lancaster General Hospital, Lancaster, Mr. W. M. Breitinger, superintendent.
- Lankenau Hospital, Philadelphia, Dr. Henry F. Page, superintendent.

- McKeesport Hospital, McKeesport, Mr. D. F. Owen, superintendent.
- Mercy Hospital, Altoona, Miss Laura M. Hamer, R.N., superintendent.
- \*\*\*Mercy Hospital, Pittsburgh, Sister M. Innocent, superintendent.
- Montgomery Hospital, Norristown, Miss Eliza Davies, R.N., superintendent.
- \*Mt. Sinai Hospital, Philadelphia, Dr. Albert S. Hyman, superintendent.
- \*Oil City Hospital, Oil City, Miss Clara B. Peck, superintendent.
- Robert Packer Hospital, Sayre, Mr. Howard E. Bishop, superintendent.
- \*Pennsylvania Hospital, Philadelphia, Mr. Daniel D. Test, superintendent.
- Pittsburgh Hospital, Pittsburgh, Mother Superior, in charge.
- \*Pittston Hospital Association, Pittston, Miss Esther J. Tinsley, superintendent.
- \*\*St. Francis Hospital, Pittsburgh, Mother Superior in charge.
- St. Joseph's Hospital, Lancaster, Mother Superior in charge.
- \*\*St. Joseph's Hospital & Dispensary, Pittsburgh, Mother Superior in charge.
- St. Luke's Homeopathic Hospital, Philadelphia, Mr. J. W. Meister, superintendent.
- St. Luke's Hospital, Bethlehem, Mr. Howard E. Neumer, superintendent.
- \*St. Margaret's Memorial Hospital, Pittsburgh, Miss O. M. Freck, R.N., superintendent.
- South Side Hospital of Pittsburgh, Pittsburgh, Miss Jeanette L. Jones, superintendent.
- Stetson Hospital, Philadelphia, Miss Katharine T. Roelop, superintendent.
- Suburban General Hospital, Bellevue, Miss Eva M. Braun, R.N., superintendent.
- \*Warren General Hospital, Warren, Miss Margaret McLaren, R.N., superintendent.
- West Philadelphia Hospital for Women, Philadelphia, Dr. Mary R. Lewis, superintendent.
- \*Wilkes-Barre City Hospital, Wilkes-Barre, Mr. Elmer E. Matthews, superintendent.
- Women's Southern Homeopathic Hospital, Philadelphia, Dr. Lydia W. Stokes, superintendent.

#### RHODE ISLAND

Homeopathic Hospital of Rhode Island, Providence, Miss E. J. L. Clapp, superintendent.  
Memorial Hospital, Pawtucket, Miss Nelle M. Selby, superintendent.

#### SOUTH CAROLINA

Anderson County Hospital, Anderson, Miss Rosa H. Nickles, superintendent.  
Greenville City Hospital, Greenville, Miss Ethel A. Johnson, superintendent.  
\*Roper Hospital, Charleston, Mr. F. Oliver Bates, superintendent.  
Steadly Clinic & Sanitarium, Chick Springs, Mrs. Frances M. Montgomery, superintendent.

#### SOUTH DAKOTA

\*Methodist Deaconess Hospital, Rapid City, Miss Elva L. Wade, R.N., superintendent.

#### TENNESSEE

Baird-Dulaney Hospital, Dyersburg, Dr. E. H. Baird, superintendent.  
\*Gartley-Ramsay Hospital, Memphis, Drs. G. Gartly and R. G. Ramsay, physicians in charge.  
Newell and Newell Sanitarium, Chattanooga, Miss Maud A. Heaton, R.N., superintendent.  
West Ellis Hospital, Chattanooga, Miss Carolyn E. Ferree, superintendent.

#### TEXAS

All Saints Hospital, Fort Worth, Miss Margery House, R.N., superintendent.  
\*\*Baptist Sanitarium & Hospital, Houston, Mr. Robert Jolly, superintendent.  
\*\*\*Baylor Hospital, Dallas, Mr. J. B. Franklin, superintendent.  
Robert B. Green Memorial Hospital, San Antonio, Dr. H. Philip Hill, superintendent.  
\*\*\*Hermann Hospital, Houston, Mr. W. A. Childress, manager.  
Lubbock Sanitarium, Lubbock, Miss E. DeMinck, R.N., superintendent.  
Physicians and Surgeons Hospital, Corsicana, Mr. S. H. Hornbeak, superintendent.  
\*\*Sanitarium of Paris, Paris, Miss Elizabeth M. Hilf, superintendent.  
Sherman Hospital, Sherman, Dr. E. J. Neathery, superintendent.

#### UTAH

Holy Cross Hospital, Salt Lake City, Mother Superior in charge.

St. Mark's Hospital, Salt Lake City, Mrs. N. F. W. Crossland, superintendent.

Tooele General Hospital, Tooele, Dr. J. A. Phipps, owner.

#### VERMONT

\*Rutland Hospital, Rutland, Miss Mary C. Newell, R.N., superintendent.

St. Albans Hospital, St. Albans, Dr. T. Allen McCormick, superintendent.

#### VIRGINIA

Edmunds' Hospital, Danville, Mrs. R. V. Blankenship, R.N., superintendent.

\*Stuart Circle Hospital, Richmond, Miss Rose Z. Van Vort, R.N., superintendent.

#### WASHINGTON

Lakeside Hospital, Seattle, Miss Cora West, R.N., superintendent.

St. Joseph's Hospital, Aberdeen, Mother Superior in charge.

\*Tacoma General Hospital, Tacoma, Mr. C. J. Cummings, manager.

#### WEST VIRGINIA

\*Hoffman Hospital, Keyser, Mr. C. S. Hoffman, owner.

\*Ohio Valley General Hospital Association, Wheeling, Dr. C. D. Wilkins, superintendent.

Parkersburg City Hospital, Parkersburg, Miss Emma Vernon, R.N., superintendent.

#### WISCONSIN

\*Columbia Hospital, Milwaukee, Dr. Kiley, superintendent.

\*Grandview Hospital, La Crosse, Miss Nellie Pierce, R.N., superintendent.

\*Madison General Hospital, Madison, Mr. H. K. Thurston, manager.

\*Milwaukee Children's Hospital, Milwaukee, Miss Gertrude I. McKee, R.N., superintendent.

\*Milwaukee Hospital, Milwaukee, Rev. Herm. L. Fritschel, superintendent.

Milwaukee Infant's Hospital, Milwaukee, Miss Nan Dinneen, superintendent.

\*Milwaukee Maternity & General Hospital, Milwaukee, Mrs. G. B. Hipke, superintendent.

\*Mt. Sinai Hospital, Milwaukee, Miss Helen S. Nipperman, superintendent.

Oconto County and City Hospital, Oconto, Mr. Eldred Klauser, superintendent.  
Roosevelt General Hospital, Milwaukee, Dr. Frederick N. Sauer, superintendent.  
St. Luke's Hospital, Racine, Miss Eva C. Greisen, R.N., superintendent.  
Theda Clark Memorial Hospital, Neenah, Miss Louisa M. Leppert, superintendent.

#### WYOMING

Casper Private Hospital, Casper, Mrs. Harry Baker, superintendent.  
Wheatland Hospital, Wheatland, Dr. Fred W. Phifer, physician in charge.

#### CANADA

Edmonton Hospital Board, Edmonton, Alberta, Dr. Harry R. Smith, superintendent.  
Hospital for Sick Children, Toronto, Ontario, Miss Florence J. Potts, superintendent.  
Hotel Dieu Hospital, Campbellton, New Brunswick, Sister Audet, superintendent.  
Hotel Dieu Hospital, Chatham, New Brunswick, Sister Droyer, superintendent.  
\*Montreal General Hospital, Montreal, Quebec, Dr. A. K. Haywood, superintendent.  
Nicholls' Hospital, Peterboro, Ontario, Mrs. E. M. Leeson, superintendent.  
Toronto General Hospital, Toronto, Ontario, Dr. Chester J. Decker, superintendent.  
\*Vancouver General Hospital, Vancouver, British Columbia, Dr. Malcolm T. MacEachern, superintendent.  
Victoria Hospital, London, Ontario, Mr. T. H. Heard, superintendent.  
\*Winnipeg General Hospital, Winnipeg, Manitoba, Dr. George F. Stephens, superintendent.  
\*\*Women's Hospital, Montreal, Quebec, Miss E. F. Trench, superintendent.

#### Associate

#### ILLINOIS

Illinois Society of Occupational Therapists, Chicago, Miss Katherine C. Staples, president.  
National Hospital Day Committee, 537 South Dearborn Street, Chicago, Mr. Matthew O. Foley, executive secretary.  
Woman's Auxiliary Board of the Presbyterian Hospital, Chicago, Mrs. Perkins B. Bass, president.

## NEW YORK

Joint Administrative Board of the Columbia University  
and Presbyterian Hospital, New York City, Dr. C. C.  
Burlingame, executive officer.

## PERSONAL MEMBERS

### Active and Associate

\*Members registering attendance at the 1921 conference.

### ALABAMA

Davis, R.N., Miss Ruth, superintendent, Vaughan  
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\*Glasgow, Mr. M. Whitfield, superintendent, Employees'  
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Golightly, Mrs. B. E., superintendent, Birmingham In-  
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\*Incor, Miss Ida S., superintendent, Moody Hospital,  
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\*MacLean, R.N., Miss Helen, superintendent, Fraternal  
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### ALASKA

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Tye, Miss Menia S., superintendent, Sparks Memorial  
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Whittaker, Miss Anna J., superintendent Sparks Me-  
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- Henninger, R.N., Miss Alice G., superintendent. Seaside Hospital, Long Beach.
- \*Klaeser, Miss Florence, manager, White Hospital, Sacramento.
- Levison, Mr. J. B., trustee, Mount Zion Hospital, San Francisco.
- Moffitt, Mr. J. K., First National Bank, San Francisco.
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- \*Nuzum, Dr. F. R., medical director, Santa Barbara Cottage Hospital, Santa Barbara.
- O'Connor, Mr. John, superintendent, St. Francis Hospital, San Francisco.
- Shatto, Miss Katherine, U. S. Veterans' Bureau, Los Angeles.
- Somers, Dr. Geo. B., superintendent, Lane Hospital, San Francisco.
- Wallace, Miss Margaret M., superintendent, Community Hospital, Santa Ana.
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- Corwin, Dr. R. W., superintendent, Minnequa Hospital, Pueblo.
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- Holden, Dr. G. W., superintendent, Agnes Memorial Sanitarium, Denver.
- Lamborn, Mr. H., superintendent, Park Avenue Hospital, Denver.
- Simon, Dr. S., National Jewish Hospital for Consumptives, Denver.
- Swezey, Dr. Samuel, superintendent, National Jewish Hospital for Consumptives, Denver.

## CONNECTICUT

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- Des Jardin, Miss Claire A., assistant superintendent, New Britain General Hospital, New Britain.
- Dowd, Miss Kathleen A., superintendent nurses, Wm. W. Backus Hospital, Norwich.
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- Kochersperger, Mr. H. M., trustee, Grace Hospital Society, New Haven.
- Love, Miss May L., superintendent, Litchfield County Hospital, Winsted.
- MacIver, Dr. George A., Out-Patient Department, New Haven Hospital, New Haven.
- Mallory, Mr. Charles A., president, Danbury Hospital, Danbury.
- McGarry, Miss Mary C., superintendent, Charter Oak Private Hospital, Hartford.
- Medd, Rev. Henry, Pastor, St. Paul's Methodist Episcopal Church, Waterbury.
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- Murphy, Dr. James E., Wildwood Sanatorium, Hartford.

- Palmer, Mr. Chas. S., member, Grace Hospital Society, New Haven.
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- Woodruff, Mr. Rolin S., trustee, Grace Hospital, New Haven.

#### DELAWARE

- \*Pugh, Miss M. Louise, superintendent, Homeopathic Hospital, Wilmington.
- Reilly, Miss Helen T., superintendent, Hope Farm Sanatorium, Marshallton.
- Shaw, Mr. Benj. F., trustee, Delaware Hospital, Wilmington.
- Sparrow, Miss Caroline E., superintendent, Delaware Hospital, Wilmington.
- Turner, Miss Alida H., Homeopathic Hospital, Wilmington.

#### DISTRICT OF COLUMBIA

- Goodnow, Miss Minnie, superintendent nurses, Children's Hospital.
- \*Mays, Mr. James R., superintendent, Garfield Memorial Hospital.
- Moore, Miss Frances W., Sibley Hospital.
- Thompson, Miss Birdie B., superintendent, George Washington University Hospital.
- Warfield, Dr. William A., superintendent, Freedman's Hospital.

#### FLORIDA

- \*Hollohan, R.N., Miss Lillian A., superintendent, Morton F. Plant Endowed Hospital, Clearwater.
- \*Larrabee, R.N., Mrs. Dovie C., superintendent, Larrabee Hospital, Bradentown.

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#### ILLINOIS

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- \*Henderson, Miss Bena M., superintendent, Children's Memorial Hospital, Chicago.
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- \*Lapp, Mr. John A., director, Social Action Dept., National Catholic Welfare Council, Chicago.
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- \*Merrill, Dr. L. C., superintendent, Illinois General Hospital, Chicago.

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- \*Sanders, Mr. E. E., superintendent, Ravenswood Hospital, Chicago.
- Schmidt, Mr. Richard E., vice-president, Grant Hospital, Chicago.
- \*Schreiber, Mr. Geo. F., architect, 105 W. Monroe St., Chicago.
- Shrader, Miss Florence R., superintendent, Jarman Memorial Hospital, Tuscola.
- \*Smith, Dr. Herman, superintendent, Michael Reese Hospital, Chicago.
- Sporland, Sister Ingeborg, superintendent, Lutheran Deaconess Home & Hospital, Chicago.



- \*Surbray, Miss Mary E., superintendent, John C. Proctor Hospital, Peoria.
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- Venner, Miss Ida B., superintendent, Passavant Memorial Hospital, Jacksonville.
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- \*Weber, Dr. Geo. T., superintendent, Olney Sanitarium, Olney.
- \*Weber, Mr. Jos. J., managing editor, Modern Hospital Publishing Co., Chicago.
- Weber, Miss Katharina, superintendent nurses, Olney Sanitarium, Olney.
- Weber, Miss Minnie R., superintendent nurses, Olney Sanitarium, Olney.
- \*Webster, Mr. John W., chairman executive committee, Lakeview Hospital, Danville.
- \*Wilson, Miss Martha, trustee, Children's Memorial Hospital, Chicago.
- Young, Dr. C. O., president, Washington Park Hospital, Chicago.

#### INDIANA

- \*Braun, Sister Carolina, superintendent, Protestant Deaconess Hospital, Evansville.
- \*Carter, Dr. Amos, superintendent, Indiana State Sanatorium, Rockville.
- \*Clarke, Mrs. Ethel P., Robert W. Long Hospital, Indianapolis.
- \*Combs, Dr. Chas. N., superintendent, Union Hospital, Terre Haute.
- \*Duemling, Dr. H. A., Lutheran Hospital, Fort Wayne.
- \*Elkins, Miss Myrtle E., superintendent, Miami County Hospital, Peru.
- \*Goeppinger, Miss L. L., Deaconess Hospital, Indianapolis.

- \*Gross, Dr. W. O., Lutheran Hospital, Fort Wayne.
- \*Hayden, Dr. A. M., Hayden Hospital, Evansville.  
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- \*McClaslin, Miss Ida, secretary, State Board Examiner, Lebanon.  
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- \*Medendorp, Miss Anna, superintendent, Home Hospital, LaFayette.  
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#### IOWA

- Alderson, Dr. James, trustee, Finley Hospital, Dubuque.
- \*Beers, Miss Amy, superintendent, Jefferson County Hospital, Fairfield.  
Elder, Miss Mary E., superintendent, Burlington Hospital, Burlington.
- \*Garrison, Miss Charlotte Jane, superintendent, Sunny Crest Sanatorium, Dubuque.  
Gratiot, Dr. H. B., president Med. Staff, Finley Hospital, Dubuque.
- \*Hanson, Rev. F. O., superintendent, Iowa Lutheran Hospital, Des Moines.  
Jackson, Miss Mary C., superintendent, W. C. Graham Hospital, Keokuk.

- Kern, Miss Barbara E. Jacobson, Synodical Presbyterian Hospital, Waterloo.
- Lomas, Dr. A. J., superintendent, University Hospital, Iowa City.
- \*Marsh, R.N., Miss Lillian, superintendent, Mary Frances Skiff Hospital, Newton.
- Matthews, Mr. Francis C., superintendent, New Samaritan Hospital, Sioux City.
- \*Northrop, R.N., Miss N. Adele, superintendent, Finley Hospital, Dubuque.
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- Sampson, Dr. F. E., chief of medical staff, Greater Community Hospital, Creston.

#### KANSAS

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- \*Ascher, Mr. Samuel G., superintendent, Wichita Hospital, Wichita.
- Briggs, Mrs. Charlotte, superintendent, Hutchinson Hospital, Hutchinson.
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- Fahy, Miss Ellen, superintendent nurses, Axtell Hospital, Newton.
- Krehbiel, Miss L. P., superintendent, Halstead Hospital, Halstead.
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- Wilson, Miss Pearl, superintendent, Sabetha Hospital, Sabetha.

#### KENTUCKY

- Combs, Mr. Alfred, trustee, Good Samaritan Hospital, Lexington.
- \*Cowles, Miss Annette B., Children's Free Hospital, Louisville.
- Fisher, Miss Clara A., superintendent, Jewish Hospital, Louisville.
- \*Gaggs, Miss Alice Muriel, superintendent, J. N. Norton Memorial Infirmary, Louisville.
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#### LOUISIANA

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#### MAINE

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- Potter, Miss Lucy J., superintendent, Trull Hospital, Biddeford.
- Smith, Dr. Charles D., superintendent, Maine General Hospital, Portland.
- \*Stone, Dr. George H., superintendent, Eastern Maine General Hospital, Bangor.
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#### MARYLAND

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#### MASSACHUSETTS

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Bigelow, Mr. Walter K., trustee, Salem Hospital, Salem.

Bigelow, Mr. Wilbur B., superintendent, Salem Hospital, Salem.

Booker, Miss Elizabeth M., superintendent, Corey Hill Hospital, Brookline.

Bray, Mr. William C., trustee, Newton Hospital, Newton Lower Falls.

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Brooks, Mr. William Allen, trustee, Brooks Hospital, Brookline.

- Burt, Mrs. Bertha Hart, superintendent, Hart Private Hospital, Roxbury.
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- \*Catton, Miss Jessie E., superintendent, Lawrence General Hospital, Lawrence.
- \*Cleave, Miss K. Frances, Simmons College, Boston.
- Coleman, Miss Laura E., superintendent, Jordan Hospital, Plymouth.
- Coleman, Miss Louise M., superintendent, House of the Good Samaritan, Boston.
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- Smith, R.N., Miss Nina A., superintendent nurses, Robert Packer Hospital, Sayre.
- Snyder, Dr. E. S., St. Joseph's Hospital, Lancaster.
- Stokes, Dr. Lydia Webster, superintendent, Women's Southern Homeopathic Hospital, Philadelphia.
- Stockwell, Mr. Herbert G., 833 Land Title Bldg., Philadelphia.
- Styer, R.N., Miss Anna L., superintendent, Maple Avenue Hospital, Du Bois.
- \*Tannenbaum, Dr. Simon, superintendent, Jewish Hospital, Philadelphia.
- \*Test, Mr. Daniel D., superintendent, Pennsylvania Hospital, Philadelphia.
- \*Tinsley, Miss Esther J., superintendent, Pittston Hospital, Pittston.
- Ubil, Miss Katherine S., superintendent, J. Lewis Crozier Homeopathic Hospital, Chester.
- Viehdorfer, Miss Alma M., superintendent, Allentown Hospital, Allentown.
- Ward, Miss Maud, Friend's Hospital, Frankford, Philadelphia.
- \*Weiss, Dr. E. A., surgeon, Mercy Hospital, Pittsburgh.
- West, Miss Roberta M., secretary & treasurer, Pennsylvania State Board of Examiners for the Registration of Nurses, Oak Lane P. O., Philadelphia.
- Whiting, Dr. A. D., medical director, Germantown Hospital, Philadelphia.
- Whiton, Miss Lydia A., superintendent, Meadville City Hospital, Meadville.
- Wilson, Miss Caroline M., superintendent, Franklin Hospital, Franklin.
- Wilson, Mr. Geo. W., superintendent, Hamot Hospital, Erie.
- Wilson, Miss Margaret S., superintendent, Orthopedic Hospital, Philadelphia.
- Woodside, Miss Margaret W., superintendent, Braddock General Hospital, Braddock.
- Xavier, Sister M., superintendent, St. Joseph's Hospital, Reading.

Yingst, Miss Edith E., superintendent, Carlisle Hospital, Carlisle.

Ziegler, Dr. Chas. Edward, medical director, Elizabeth Steel Magee Hospital, Pittsburgh.

\*Zulauf, Dr. G. Walter, superintendent, Allegheny General Hospital, Pittsburgh.

Zulick, Dr. Thos. C., hospital surgeon, Easton Hospital, Easton.

#### RHODE ISLAND

Ayers, Miss Lucy G., superintendent, Woonsocket Hospital, Woonsocket.

\*Bates, Dr. W. Lincoln, Dr. Bates Sanitarium, Jamestown.

Blumer, Dr. G. Alder, superintendent, Butler Hospital, Providence.

Easton, Mr. Fred W., first vice-president, Memorial Hospital, Pawtucket.

Heimer, Dr. W. H., superintendent, Park Place Hospital, Pawtucket.

Jones, Dr. Arthur T., surgeon, Memorial Hospital, Pawtucket.

Jones, Dr. Henry A., superintendent, State Infirmary, Howard.

Littlefield, Mr. E. N., trustee, Memorial Hospital, Pawtucket.

MacLeod, Dr. Norman, Newport Hospital, Newport.

Moulton, Mr. David P., trustee, Homeopathic Hospital of Rhode Island, Providence.

Oulton, Dr. Lamert, assistant visiting surgeon, Memorial Hospital, Pawtucket.

\*Peters, Dr. John M., superintendent, Rhode Island Hospital, Providence.

Read, Mr. Chas. O., trustee, Memorial Hospital, Pawtucket.

\*Richardson, Dr. D. L., superintendent, City Hospital, Providence.

Selby, Miss Nelle M., superintendent, Memorial Hospital, Pawtucket.

Washburn, Dr. Elliott, Room 305, 109 Washington St., Providence.

#### SOUTH CAROLINA

\*Bates, Mr. F. O., superintendent, Roper Hospital, Charleston.

Clark, Mr. W. Julian, superintendent, Columbia Hospital, Columbia.

\*Heinrich, Miss Mary E., superintendent, Tuomey Hospital, Sumter.

McConnell, Miss Anastasia, assistant superintendent, Roper Hospital, Charleston.  
Middleton, Miss Nell Dean, superintendent, Steedly's Private Hospital, Spartansburg.  
Montgomery, Mrs. Frances M., superintendent, Steedly Clinic Sanitarium, Chick Springs.  
Robbins, Miss Etta L., superintendent, Camden Hospital, Camden.

#### SOUTH DAKOTA

Elizabeth, Sister M., assistant superintendent, St. Joseph's Hospital, Deadwood.  
\*Kettering, Miss V. A., superintendent, Methodist State Hospital, Mitchell.  
Martina, Sister M., superintendent nurses, Our Lady of Lourdes Hospital, Hot Springs.  
\*Moe, Dr. Anton J., Moe Hospital, Sioux Falls.  
Moe, R.N., Miss Frances, superintendent, Moe Hospital, Sioux Falls.

#### TENNESSEE

Haggard, Dr. W. D., hospital surgeon, Vanderbilt and St. Thomas Hospitals, Nashville.  
Hedden, Dr. Henry, superintendent, Methodist Hospital, Memphis.  
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\*Purvis, Mr. Joseph, superintendent, Memphis General Hospital, Memphis.  
\*Sheats, Mr. George D., assistant superintendent, Baptist Memorial Hospital, Memphis.  
Townsend, Dr. David, associate medical director & superintendent, National Soldiers' Home, Johnson City.  
Wilkes, Mr. P. C., Motor Batteries Co., Union Avenue, Memphis.  
Wootton, Miss Nina E., Woman's Hospital of the State of Tennessee, Nashville.

#### TEXAS

Clay, R.N., Miss E. D., superintendent, John Sealy Hospital, Galveston.  
\*Franklin, Mr. J. B., superintendent, Baylor Hospital, Dallas.  
Gants, R.N., Miss Florence, superintendent, Texarkana Sanitarium & Hospital, Texarkana.

Hill, Dr. H. P., superintendent, Robert B. Green Memorial Hospital, San Antonio.  
 Leake, Miss Daisy H., superintendent, Temple Sanitarium, Temple.  
 Middleton, Miss Ila M., 6039 Palo Pinto Ave., Dallas.  
 Newton, Dr. W. R., trustee, Cameron Hospital, Cameron.  
 Putts, Miss Mary J., superintendent, King's Daughters Hospital, Temple.  
 Thompson, Mrs. A. W., superintendent, Protestant Hospital, Fort Worth.  
 Treat, Dr. C. R., superintendent, Cornick Bungalows Hospital & Sanatorium for Tuberculosis, San Angelo.  
 Webster, Miss Carrie, superintendent, Wichita General Hospital, Wichita Falls.  
 \*Woody, Dr. McIver, surgeon in chief, Baylor Hospital, Dallas.

#### UTAH

Crossland, Mrs. Nellie F. W., superintendent, St. Marks Hospital, Salt Lake City.  
 Grant, Mr. B. F., superintendent, Dr. W. H. Groves Latter-Day Saints Hospital, Salt Lake City.  
 \*Rawson, Mr. W. W., superintendent, Thomas D. Dee Memorial Hospital, Ogden.  
 Superior, Sister, superintendent, Holy Cross Hospital, Salt Lake City.

#### VERMONT

Baker, Miss Mary Alberta, superintendent, Henry W. Putnam Memorial Hospital, Bennington.  
 \*Bradley, Mr. R. M., trustee Brattleboro Memorial Hospital, Brattleboro (60 State St., Boston, Mass.).  
 Brown, Dr. Thomas S., superintendent, Mary Fletcher Hospital, Burlington.  
 Lawton, Dr. S. E., superintendent, Brattleboro Retreat, Brattleboro.  
 \*Newell, R.N., Miss Mary Carr, superintendent, Rutland Hospital, Rutland.  
 Spinney, Miss Julia B., superintendent, Springfield Hospital, Springfield.  
 Summersgill, Dr. H. T., Bennington Club, Bennington.  
 \*Wood, Miss Helen B., superintendent, Proctor Hospital, Proctor.

#### VIRGINIA

Anderson, R.N., Mrs. H. E., superintendent, Clinchfield Hospital, Dante.  
 Bishop, Miss Florence A., superintendent, Kings Daughters Hospital, Portsmouth.



- Blankenship, Mrs. R. V., superintendent, Edmunds Hospital, Danville.
- Brian, R.N., Miss Celia, superintendent, Danville General Hospital, Danville.
- Edwards, R.N., Miss Fannie R., superintendent, Clinchfield Hospital, Dante.
- Morgan, Dr. Esther, superintendent nurses, Hampton Training School for Nurses, Hampton.
- Morlock, Mr. Frederic B., superintendent, Memorial Hospital, Richmond.
- Odom, Mr. L. L., superintendent, Sarah Leigh Hospital, Norfolk.
- Thacker, Miss S. Virginia, superintendent, Lewis-Gale Hospital, Roanoke.
- Trout, Dr. Hugh A., chief surgeon, Jefferson Surgical Hospital, Roanoke.
- Turner, R.N., Miss Bessie W., night supervisor, Edmunds' Hospital, Danville.
- \*Van Vort, Miss Rose Z., superintendent, Stuart Circle Hospital, Richmond.

#### WASHINGTON

- Cary, Dr. Raymond J., Oakhurst Sanatorium, Elma.
- \*Cummings, Mr. C. J., superintendent & manager, Tacoma General Hospital, Tacoma.
- Day, Mrs. Elizabeth M., superintendent, Lakeside Hospital, Seattle.
- Greene, Miss Leitia A., 1208 Carlisle Avenue, Spokane.
- \*Hall, R.N., Miss Evelyn H., superintendent, Seattle General Hospital, Seattle.
- Lutz, Miss Bertha M., assistant superintendent, Deaconess Hospital, Spokane.
- Mason, Dr. J. Tate, superintendent, King County Hospital, Seattle.

#### WEST VIRGINIA

- Abbott, Mr. W. H., trustee, Ohio Valley General Hospital, Wheeling.
- Agnes, Sister Mary, superintendent, St. Mary's Hospital, Clarksburg.
- Behrens, Mr. H. F., trustee, Ohio Valley General Hospital, Wheeling.
- Bowers, Mr. Chas. A., trustee, Ohio Valley General Hospital, Wheeling.
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- Coleman, Dr. J. E., physician in Charge, Beckley Hospital, Beckley.
- Dominic, Sister M., Wheeling Hospital, Wheeling.
- French, Miss Nellie S., superintendent, St. Luke's Hospital, Bluefield.
- Fuqua, Mr. C. B., business manager, St. Luke's Hospital, Bluefield.
- Goodman, Mr. W. L., superintendent, McKendrie Hospital No. 2, McKendrie.
- Hoffman, Mr. C. S., superintendent, Hoffman Hospital, Keyser.
- Hoffman, Miss Margaret, dietitian, Ohio Valley General Hospital, Wheeling.
- Hubbard, Mr. Nelson C., trustee, Ohio Valley General Hospital, Wheeling.
- Lynch, Miss A. T., superintendent nurses, St. Luke's Hospital, Bluefield.
- McMillan, Dr. W. A., physician in charge, McMillan Hospital, Charleston.
- Paxton, Mr. A. B., trustee, Ohio Valley General Hospital, Wheeling.
- Peterson, Mr. B. W., president, Ohio Valley General Hospital, Wheeling.
- Vernon, R.N., Miss Emma, superintendent, Camden-Clark Hospital, Parkersburg.
- Vickers, Dr. Robert E., owner, Mount Hope Hospital, Huntington.
- \*Wilkins, Dr. C. D., superintendent, Ohio Valley General Hospital, Wheeling.

#### WISCONSIN

- Bass, Miss Catherine E., superintendent, Sunnyview Sanatorium, Winnebago.
- Bellin, Dr. Julius J., staff member, Wisconsin Deaconess Hospital, Green Bay.
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- Brown, R.N., Miss Marguerite D., superintendent, Milwaukee Infant's Hospital, Milwaukee.
- \*Bruce, Mr. Frank, Hospital Progress, Milwaukee.
- Bruce, Mr. Wm. C., editorial board, Hospital Progress, Milwaukee.
- Clark, Mr. Chas. B., president, Theda Clark Memorial Hospital, Neenah.

- Cohen, Mrs. Dora, manager, I. N. Cohen's Private Sanatorium, La Crosse.
- Coon, Dr. J. W., president & medical director, River Pines Sanitarium, Stevens Point.
- Darling, Dr. U. G., superintendent, Lake Geneva Sanatorium & Hospital, Lake Geneva.
- Dietrickson, R.N., Miss Levina S., superintendent, Forest Lawn Sanatorium, Jefferson.
- Egeland, Dr. G. R., trustee, Egeland Hospital, Sturgeon Bay.
- \*Fritschel, Rev. Herm L., superintendent & president, Milwaukee Hospital, Milwaukee.
- Goodrich, Dr. J. K., staff member, Riverview Hospital, Wisconsin Rapids.
- \*Henke, Mr. W. A., superintendent medical staff, Grandview Hospital, La Crosse.
- \*Hipke, Mrs. G. A., superintendent, Milwaukee Maternity & General Hospital, Milwaukee.
- Ide, Dr. Chas. E., superintendent, Muirdale Sanitarium, Wauwatosa.
- Ingwerson, Miss Ella C., superintendent, La Crosse Hospital, La Crosse.
- Irish, Mr. J. W., executive secretary, Wisconsin Methodist Hospital Association, Madison.
- Klauser, Mr. Eldred, general manager, Oconto County & City Hospital, Oconto.
- Lucia, R.N., Miss Mildred H., superintendent, Mt. Washington Sanitarium, Eau Claire.
- Lyon, R.N., Miss Ruth L., superintendent, Lakeside Methodist Hospital, Rice Lake.
- \*McKee, R.N., Miss Gertrude I., superintendent, Milwaukee Children's Hospital, Milwaukee.
- Meachem, Dr. J. G., president, St. Luke's Hospital, Racine.
- Mutschmann, R.N., Miss Joan, superintendent, La Crosse Lutheran Hospital, La Crosse.
- \*Olson, R.N., Miss Amelia C., superintendent, Lutheran Hospital, Eau Claire.
- Paulson, R.N., Miss Hannah, superintendent, Wisconsin Deaconess Hospital, Green Bay.
- Peacock, Dr. J. H., business manager, Prairie du Chien Sanitarium & Hospital, Prairie du Chien.
- Pease, R.N., Miss Bessie M., superintendent, Wisconsin Methodist Hospital Association, Madison.
- Pfeiffer, R.N., Miss Charlotte, assistant superintendent, Evangelical Deaconess Hospital, Milwaukee.

- Pinkerton, Dr. W. T., medical director, Prairie du Chien Sanitarium & Hospital. Prairie du Chien.
- Reid, R.N., Miss Agnes W., superintendent, State of Wisconsin General Hospital, Madison.
- Rottman, R.N., Miss Marion, superintendent, Johnston Emergency Hospital, Milwaukee.
- Sauer, Dr. F. N., staff member, Roosevelt General Hospital, Milwaukee.
- Schroeder, Dr. J. C., trustee, Hanover General Hospital, Milwaukee.
- Schulz, Dr. F. M., superintendent, Milwaukee County Hospital, Wauwatosa.
- Schute, R.N., Miss C. A., superintendent, Hillsboro Hospital, Hillsboro.
- Seraphia, C.S.A., Sister M., superintendent, St. Agnes Hospital, Fond du Lac.
- \*Smith, R.N., Miss Ella Barnaby, superintendent, Wausau Hospital, Wausau.
- Smith, Dr. S. M., president, Hanover General Hospital, Milwaukee.
- Sperber, R.N., Miss Helen, superintendent, Egeland Hospital, Sturgeon Bay.
- Strauss, Dr. O. A., staff member, Hanover General Hospital, Milwaukee.
- Thurston, Mr. H. K., business manager, Madison General Hospital, Madison.
- Uhlman, Mr. Leo, trustee Mt. Sinai Hospital, Milwaukee.
- Voje, Dr. J. H., superintendent, Waldheim Park Sanitarium, Oconomowoc.
- White, Miss Regine, 419 E. Water St., Milwaukee.
- Wiley, Dr. F. S., chief of staff, St. Agnes Hospital, Fond du Lac.
- Williams, Dr. R. L., superintendent, Wisconsin State Tuberculosis Sanatorium, Statesan.
- \*Wipperman, Miss Helen S., superintendent, Mt. Sinai Hospital, Milwaukee.

#### WYOMING

- Lathrop, Dr. H. R., president, Casper Private Hospital, Casper.
- Phifer, Mrs. Margaret, Wheatland Hospital, Wheatland.

#### CANADA

- Alexander, Dr. A. B., superintendent, Winnipeg Municipal Hospital, Winnipeg, Manitoba.
- \*Barnes, Dr. E. C., medical superintendent, Hospital for Mental Diseases, Selkirk, Manitoba.

- Barry, Miss Lily E. F., social service worker, Catholic Social Service Guild, Montreal, Quebec.
- Bayne, R.N., Miss Gladys M., superintendent, Sherbrooke Hospital, Sherbrooke, Quebec.
- Beamish, Miss E. M.
- Bernard, Sister M., St. John's Hospital, St. John's Newfoundland.
- Bowman, Mrs. H. M. F., superintendent, Women's College Hospital, Toronto, Ontario.
- Craig, Miss Jane, superintendent nurses, Western Hospital, Quebec, Quebec.
- Dickson, Mr. E. Mack, superintendent, Toronto Free Hospital for Consumptives, Weston, Ontario.
- Fairley, Miss Grace M., superintendent, Training School for Nurses, Hamilton, Ontario.
- Ferguson, Miss C. M., superintendent, Alexandra Hospital, Montreal, Quebec.
- Flaws, Miss Elizabeth G., superintendent, The Wellesley Hospital, Toronto, Ontario.
- Froud, Mr. Walter E., superintendent, Iroquois Falls Hospital, Iroquois Falls, Ontario.
- Gartshore, Mr. W. M., trustee, Victoria Hospital, London, Ontario.
- Garvin, Miss Gertrude P., superintendent nurses, Isolation Hospital, Ottawa, Ontario.
- Gosselin, Dr. J., superintendent, Civic Hospital, Quebec, Quebec.
- Haddon, Mr. George, secretary, Vancouver General Hospital, Vancouver, British Columbia.
- \*Haywood, Dr. A. K., superintendent, General Hospital, Montreal, Quebec.
- Heard, Mr. T. H., superintendent Victoria Hospital, London, Ontario.
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- Keegan, Dr. L. S., superintendent, St. Johns Hospital, St. Johns, Newfoundland.
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- Langrill, Dr. Walter F., superintendent, Hamilton City Hospital, Hamilton, Ontario.
- Leonard, Mr. David Harold, manager, Royal Alexander Hospital, Edmonton, Alberta.

- \*MacEachern, Dr. Malcolm T., superintendent, Vancouver General Hospital, Vancouver, British Columbia.
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- MacKenzie, Miss Jessie, superintendent, Provincial Royal Jubilee Hospital, Victoria, British Columbia.
- Martin, R.N., Miss Mary E., superintendent nurses, Winnipeg Municipal Hospital, Winnipeg, Manitoba.
- McArthur, Miss E. J., superintendent, Stratford General Hospital, Stratford, Ontario.
- McClarty, Miss Edith A., Sutton, Quebec.
- McKay, Dr. James Gordon, acting superintendent, Provincial Hospital for Insane, Essondale, British Columbia.
- McNeel, R.N., Miss Mabel L., superintendent, Children's Hospital, Winnipeg, Manitoba.
- Meiklejohn, Miss Harriet T., director, Public Health Nursing Service, Fredericton, New Brunswick.
- Mercier, Dr. O. F., chief surgeon, Notre Dame Hospital, Montreal, Quebec.
- Munn, Mr. Alexandra M., superintendent, Stratford General Hospital, Stratford, Ontario.
- Murphy, Dr. E. V., medical superintendent, Alexandra Hospital, Montreal, Quebec.
- \*Murray, Mr. T. T., superintendent, Saskatoon City Hospital, Saskatoon, Saskatchewan.
- Potts, Miss Florence, superintendent, Children's Hospital, Toronto, Ontario.
- \*Reddy, Dr. H. L., secretary and treasurer, Women's Hospital, Montreal, Quebec.
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- Seymour, Dr. M. M., Commissioner of Public Health,



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- Shaw, Miss May, superintendent, Jeffrey Hale's Hospital, Quebec, Quebec.
- Shirieff, Mr. W. T., superintendent, Isolation Hospital, Ottawa, Ontario.
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- \*Stoker, Mr. George, secretary, Winnipeg Municipal Hospital, Winnipeg, Manitoba.
- \*Taylor, Mr. Frederick, superintendent, St. Luke's General Hospital, Ottawa, Ontario.
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- Trench, Miss E. F., superintendent, Women's Hospital, Montreal, Quebec.
- Walker, Dr. Thomas, General Public Hospital, St. John, New Brunswick.
- Wrinch, Dr. Horace C., superintendent, Hazelton Hospital, Hazelton, British Columbia.

#### NOVA SCOTIA

- Kenney, Mr. Wallace W., superintendent, Victoria General Hospital, Halifax, Nova Scotia.
- Mader, Miss Eva A., superintendent, Mader Hospital, Halifax, Nova Scotia.

#### FOREIGN

- Benson, Mr. Cyril, resident secretary, Pretoria Hospital, Pretoria, S. Africa.
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Sloan, Dr. T. Dwight, assistant medical superintendent, Peking Union Medical College Hospital, Peking, China.

Soto, Dr. Enrique Fernandez, laryngologist, Clinics Bustamonte Nunez, Havana, Cuba.

Thomson, Mr. J. Oscar, superintendent, Canton Hospital, Canton, China.

Walker, Dr. Eugene, Walher Building, Hamilton, Bermuda.

Wright, Miss Elizabeth M., superintendent, Hospital La Humanitaria, La Vega, Dominican Republic.

#### LIFE MEMBERS

Aikens, Miss Charlotte A., 138 Parkhurst Place, Detroit, Mich.

\*Bacon, Mr. Asa S., superintendent, Presbyterian Hospital, Chicago, Ill.

\*Baldwin, Dr. Louis B., superintendent, University Hospital, Minneapolis, Minn.

\*Ball, Dr. O. F., president, Modern Hospital Publishing Co., Chicago, Ill.

\*Bartine, Mr. O. H., 157 Lexington Ave., New York City, N.Y.

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Blatchford, Miss Barbara, occupational therapy department, Presbyterian Hospital, Chicago, Ill.

Blodgett, Mr. John W., president, Blodgett Memorial Hospital, Grand Rapids, Mich.

Borden, Mr. Richard P., trustee, Union Hospital, Fall River, Mass.

Broadhurst, Miss Jessie, superintendent, Broad Street Hospital, Oneida, New York.

Burns, Miss Mary A., 28 Ferris St., St. Albans, Vermont.

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Curtis, Mr. Charles P., president, Peter Bent Brigham Hospital, Boston 17, Mass.

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- \*Parnall, Dr. Christopher G., superintendent, University Hospital. Ann Arbor, Mich.
- Prentiss, Mr. F. F., president, St. Luke's Hospital, Cleveland, Ohio.
- \*Ransom, Mr. John E., superintendent, Michael Reese Dispensary, Chicago, Ill.
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- Rhodes, Mr. J. R., 329 Apsley St., Philadelphia, Pa.
- Savage, Dr. A. J. Barker, superintendent, Broad Street Hospital. New York City, N. Y.
- Stiles, Miss Wavie, 3901 Peters St., Sioux City, Iowa.
- Towns, Dr. Charles B., 293 Central Park West, New York City, N. Y.
- \*Warner, Dr. A. R., executive secretary, American Hospital Association, Chicago, Ill.
- \*Webster, Mr. H. E., superintendent, Royal Victoria Hospital, Montreal, Quebec.

# CONSTITUTION AND BY-LAWS AMERICAN HOSPITAL ASSOCIATION

(AS AMENDED AT THE ANNUAL CONFERENCE, SEPT. 12-16, 1921, WEST  
BADEN, INDIANA.)

## ARTICLE I

The name of this Association shall be "The American Hospital Association."

## ARTICLE II

The object of this Association shall be to promote the welfare of the people so far as it may be done by the institution, care and management of hospitals and dispensaries with efficiency and economy, to aid in procuring the cooperation of all organizations with aims and objects similar to those of this Association; and in general, to do all things which may best promote hospital efficiency.

## ARTICLE III

Section 1. The membership of this Association shall be—

### A. Institutional.

Any corporation or association organized for the promotion of public health or for the care or treatment of the sick or injured shall be entitled to membership subject to the following:

Active.—Active institutional members shall be institutions having direct responsibility for the care of patients however such institution may be designated.

Applications for active institutional membership shall be addressed to the Executive Secretary in writing, signed by a duly authorized representative of the corporation or association; they shall be referred to the Membership Committee and the applicant shall become a member upon receiving the approval of the majority of the Membership Committee and upon the payment of the initiation fees as follows: Hospitals with a capacity of less than 100 beds shall pay ten dollars; those from 100-250 beds, inclusive, shall pay twenty dollars; all over 250 beds shall pay thirty dollars; all other organizations eligible to active institutional membership shall pay ten dollars.

Constituent active institutional members shall be entitled to appoint as their representatives in the Association any person or persons who are eligible to active or associate membership in the Association, and of the number so appointed no more than three, including the Superintendent, shall have all the privilege and authority of active personal members and shall be so designated, and others so appointed shall have the privileges of associate personal members.

Associate.—Associate institutional members shall be corporations, associations or other organizations existing for the promotion of public health but not having direct responsibility for the care of patients.

Applications for associate institutional membership shall be addressed to the Executive Secretary in writing signed by a duly authorized representative of the corporation or association; they shall be referred to the Membership Committee and the applicant shall become a member upon receiving the approval of a majority of the Membership Committee and the payment of the dues for the first year. Constituent associate institutional members shall be entitled to appoint as their

representative any person or persons eligible to active or associate personal membership or officers of the corporations or organizations without other hospital connections, who shall have all privileges except vote.

#### B. Personal.

Active.—Active personal members shall be those who at the time of their election are trustees or superintendents, or assistant superintendents of hospitals, or members of the medical staffs of hospitals, however such officials may be designated. Any person once an active personal member may continue such membership so long as the rules of the Association are conformed with.

Associate.—Associate personal members shall, at the time of their election, be heads of any executive, administrative, or educational department of a hospital, other than as designated in Section 1B Active, or contributors to, or members of, any association or board, the object of which is the foundation, maintenance or improvement of hospitals or the promotion of organized charities for the improvement of health. Associate personal members may hold office, but shall not have the right to vote at meetings of the Association.

Applications for active or associate personal membership shall be in writing, addressed to the Executive Secretary, and shall be endorsed by one or more members of the Association. They shall be referred to the Committee on Membership; and the applicant shall become a member upon receiving the approval of a majority of said Committee, and upon payment of an initiation fee of five dollars for active and two dollars for associate membership, which shall cover the dues payable at the next convention of the Association after election.

Section 2. Upon attaining any of the offices designated in Section 1B Active an associate personal member may become an active personal member by completing the payment of the dues for active personal members as provided in the By-Laws.

Section 3. Honorary personal membership after approval of the Membership Committee may be suggested at any session of the Association by any member for any person who by reason of public or private service, or for any other reason, should be entitled to such recognition; and such person may be elected an honorary personal member by a majority vote of those present at any subsequent session of the Association.

Honorary personal members shall have all the privileges of active personal members, except voting at meetings of the Association. They shall be exempt from the payment of dues.

Section 4. Established personal memberships shall be continued for life on the payment of fifty dollars by active members and twenty-five dollars by associate members with exemption from the payment of dues.

#### ARTICLE IV: OFFICERS

Section 1. The officers of the Association shall be a President, President-elect, three Vice-Presidents, an Executive Secretary, a Treasurer, and a Board of Trustees as herein provided.

The Executive Secretary shall serve as Secretary of the Board of Trustees.

Section 2. The above officers, other than the Board of Trustees and the Executive Secretary, shall be elected at each convention. The Executive Secretary shall be appointed by the Board of Trustees. They shall assume their duties at the close of the convention and shall serve until the close of the convention next succeeding, or until their successors are regularly elected and installed. Provided, however, that

the President-elect shall assume the office of President at the next convention succeeding the convention of his election and that after the year 1919 no President shall be elected as such.

#### ARTICLE V: TRUSTEES

There shall be a Board of nine Trustees, which shall have charge of the property and financial affairs of the Association, and shall hold title thereto under the name of "Trustees of the American Hospital Association." The President, President-elect and Treasurer shall constitute three of said Trustees and two Trustees shall be elected annually, at the convention, to serve for three years, excepting that in 1919 one of said Trustees shall be elected for one year, one for two years and two for three years. Trustees shall serve until their successors are elected.

The Board of Trustees shall, always subject to the vote of the Association, have general control and management of the business of the Association, and may appoint and fix the salaries of such officers and agents as it may deem necessary and expedient and establish rules and rates for the use of such facilities as it may in its judgment provide.

#### ARTICLE VI: SECTIONS

In order to facilitate the work of the Association, sections may be formed and discontinued from time to time, as the Trustees may by vote determine. Such sections may be geographic, in order that recognized meetings of the Association may be held in various parts in places not easily accessible to all members, or may be departmental in their nature and devoted to any recognized branch of hospital work. Proceedings of any authorized section of the Association approved by the Board of Trustees may become a part of the proceedings of the Association, and any resolution adopted by a geographic section shall be recognized as a motion duly made and seconded by any general session of the Association, and vote of the general Association shall be taken thereon.

#### ARTICLE VII: ANNUAL DUES

In order to provide funds for the maintenance of the Association, both institutional and personal members shall pay annual dues as may be determined by the By-Laws.

#### ARTICLE VIII: VACANCIES

Any vacancies occurring between the regular annual meetings in the office of the President, President-elect, the various Vice-Presidents, Treasurer, Executive Secretary or Board of Trustees, shall be filled temporarily by vote of the Board of Trustees; any other vacancies shall be filled temporarily by appointment of the President; and the appointees shall hold office until their successors are elected by the Association.

#### ARTICLE IX: AMENDMENTS

The Constitution and By-Laws may be amended by vote of not less than two-thirds of the members present and voting at a recognized general session of the Association; provided, however, that proposed amendments shall be submitted in writing at a recognized general session, and shall not be acted upon at a session at which they are proposed, but may be at any subsequent session.



## BY-LAWS

### ARTICLE I

Section 1. There shall be an annual meeting or convention of the Association held at a time and place fixed by vote of the Association, or, if not so determined, by the Board of Trustees. The President and the Executive Secretary shall arrange programs for the convention.

Section 2. Special meetings may be called by the President, or in his absence, by a Vice-President, upon the written petition of not fewer than ten (10) members. This petition shall recite the object of the meeting. The President, through the Secretary, shall give notice of not less than sixty (60) days before the proposed time of such special meeting to each member of the Association, which notice shall also recite the object of the meeting.

Section 3. A quorum of the Association shall consist of not fewer than thirty (30) voting delegates or active members.

Section 4. Meetings of sections shall be held in accordance with the rules established by the enrolled members of the section hereinafter provided; provided, however, that such meetings shall not interfere with any general session of the Association.

### ARTICLE II: ELECTIONS

Section 1. All officers shall be elected by ballot, excepting where it is otherwise ordered.

Section 2. A majority of the votes cast shall constitute an election.

Section 3. Only the delegates of the constituent institutional members so authorized by Article III, Section 1, and active personal members shall be entitled to vote.

### ARTICLE III: DUTIES OF OFFICERS

Section 1. The President shall preside at all meetings of the Association, and of the Board of Trustees, of which he shall be the Chairman. He shall appoint all committees, unless, by vote of the Association, other provisions shall be made. He shall be, ex officio, a member of all standing and special committees. The President-elect shall keep in close touch with the Association work as a member of the Board of Trustees, and otherwise during the year he holds the position in preparation for his assumption of the office of President.

Section 2. The Vice-President shall, in the order of their rank, in the absence of the President, perform his duties.

Section 3. Subject to instructions from the Association or from the Board of Trustees, the Executive Secretary shall be the general executive officer of the Association with duties, responsibilities, and privileges such as generally accompany such executive positions. He shall keep the minutes of the meetings and the records of the Association in books provided for these purposes. Subject to the order of the Trustees, he may serve as secretary of standing committees, except the Committee on the Nomination of Officers, and perform such other duties as the Association and the Board of Trustees shall direct. Under the direction of the Trustees, the Executive Secretary shall report to the Association the proceedings of the Trustees and also make such report of his own services as may be advisable.

Section 4. The Treasurer shall receive all dues and other moneys of the Association and shall deposit and account for same, under the direction and control of the Board of Trustees. He shall give to said

Board such bond as it shall determine for the faithful performance of his trust. Such bond shall be in the custody of the President. All disbursements and expenditures shall be made under the direction of the Board of Trustees and subject to its rules and requirements. The Treasurer shall keep proper books of account, and shall present a report of the finances of the Association at the annual meeting.

#### ARTICLE IV

Section 1. The President shall, immediately after his election, appoint the following standing committees of three members each: namely, a Committee on Constitution and Rules, a Committee on Nomination of Officers, a Legislative Committee, a Membership Committee, and the President shall also appoint a standing committee on Out-Patient Work to consist of three members. The terms of office at the first appointment shall be so adjusted that one member shall go out of office annually. This Committee shall undertake such study or activity as may advance progress of out-patient service and shall report to the Association.

Section 2. The Committee on Nomination shall nominate to the convention the names of the candidates for President, three Vice-Presidents, Treasurer and two or more Trustees as vacancies exist. The action of this Committee is at all times subject to the approval of the convention. In the year 1919 it shall nominate a President-elect in addition to a President and thereafter shall nominate a President-elect instead of a President.

Section 3. The members of the Membership Committee shall consider all applications for membership, determine the eligibility of the applicant and express their approval or disapproval thereof to the Executive Secretary.

Section 4. The Committee on Constitution and Rules shall consider and report on all proposed amendments in the Constitution and By-Laws and all Rules of Order.

Section 5. The President shall have the power to appoint such special Committees as may be deemed desirable.

Section 6. The Legislative Committee shall, so far as possible, inform itself concerning all legislative procedure affecting the Association or the interests which it represents. Subject to the approval of the Association or Board of Trustees, it shall actively support all desirable legislation and actively oppose all unwise legislation.

#### ARTICLE V: DUES

Section 1. Constituent institutional members shall pay annual dues as follows: Hospitals of less than 100 beds shall pay annually \$10, hospitals of 100-250 beds shall pay annually \$25, hospitals of more than 250 beds shall pay annually \$50. All other institutional members shall pay annually the sum of \$10. States, counties, and municipalities shall pay in accordance with the above schedule for each institution accepted to membership. The maximum amount in such case shall, however, not exceed \$100.

Section 2. Dues of active personal members shall be \$5 and of associate personal members \$2 for each calendar year. Life personal members are exempt from the payment of annual dues. Dues shall be payable on or before the first day of March of each year at the office of the Executive Secretary, provided, however, that the dues of members acting as the delegates of institutional members shall, upon request

of such personal members to the Treasurer, be remitted for the period of delegation.

Section 3. If said dues are not paid on or before the closing of the annual convention for the current year, the Executive Secretary shall notify the members in arrears, enclosing a copy of this section; and if said dues are not paid on or before the succeeding first day of January, the delinquent member shall be suspended and thereafter shall not be entitled to receive notices, or copies of transactions, or to participate in the meetings until all arrears are paid in full.

Section 4. At any time within three years after the date when dues are first required to be paid, a member who has been suspended shall be reinstated upon the payment of the amount of dues at the time of suspension. Otherwise membership in the Association shall be terminated.

#### ARTICLE VI: PUBLICATION OF PROCEEDINGS

Section 1. The Executive Secretary shall furnish the minutes and proceedings of the regular meetings for publication as soon thereafter as practicable.

Section 2. The Executive Secretary shall furnish to each member, except as provided in Article V, Section 2, a copy of this publication.

Section 3. The Treasurer shall upon the certification of the Executive Secretary pay all bills for printing and publication of the proceedings of the regular conventions.

Section 4. No paper shall be published in the minutes or in any magazine or paper as a part of the transactions of this Association except with the approval of the Trustees. All papers read at any session of the Association or its sections shall become the property of the Association, and when so requested the Board of Trustees may cause the same to be copyrighted in the name of the Trustees; but unless prohibited by the Trustees, the authors of all papers read at sessions of the Association or its sections may cause the same to be published, and, if approved by the Trustees, they may be published as a part of the transactions of the Association. No paper or magazine shall be entitled to the exclusive publication of any paper read before the Association or its sections except by vote of the Trustees.

#### ARTICLE VII: SECTIONS

Whenever a section is established by the Association or Trustees as provided in the Constitution, the President shall appoint a chairman and secretary thereof; and thereupon any delegate or member of the Association may become a member of such section by enrollment therein. When ten (10) or more delegates or members have so enrolled, the chairman shall call a meeting of such delegates or members, and they may thereupon make proper rules and by-laws for the guidance of such section, subject to the approval of the Trustees; and such rules may provide for the method of holding meetings, election of officers, and other matters necessary or important for the proper conduct of the section. The chairman and secretary appointed by the President shall act until their successors are chosen by the members of the section in accordance with the by-laws established by such section.

#### ARTICLE VIII: GUESTS

Delegates and members of the Association may have the privilege of inviting guests to the meetings, under such rules and regulations as the Trustees may from time to time provide. Guests thus introduced shall be permitted to participate in discussions.

#### ARTICLE IX: DISCIPLINE

Section 1. All charges of violation and infraction of rules or unbecoming conduct shall be referred to a special investigating committee of five appointed by the President.

Section 2. Due notice of the charges shall be given to the alleged offender, in writing, by the Executive Secretary of the Association.

Section 3. The Association shall have the right and authority to reprimand, suspend and expel any delegate or member guilty of violation of any of the provisions of the constitution or by-laws of the Association, after a full and fair investigation shall have been made.

Section 4. A four-fifths vote shall be necessary to sustain the action of such committee.

#### ARTICLE X: AMENDMENTS

These by-laws may be amended as provided by Article IX of the constitution.

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